

**MONITORING
OF THE PRIMARY
HEALTH CARE SYSTEM
IN ALBANIA**

research study

2014

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About us

The Coalition for Free and Fair Elections and Sustainable Democracy (CFFESD) is an independent, nonpartisan Coalition founded to promote democratic governance in Albania through fostering citizen participation in public dialogue, advocacy and monitoring of public institutions and political processes.

The Coalition consists of 25 organizations and hundreds of volunteers throughout the country.

In the observation of electoral processes, the Coalition is guided by international standards of election observation and places special emphasis on issues that impact disabled and women voters. Using similar infrastructure and methodologies, the Coalition also engages citizens in monitoring institutions and key public services, such as primary healthcare in this effort.

By engaging citizens and providing nationally representative data, the Coalition seeks to bolster trust in key democratic development processes, through empowering citizens to participate in political processes by providing and advocating for recommendations for improvement.

Acronyms and abbreviations

CFFESD	Coalition for Free and Fair Election and Sustainable Democracy
DCM	Decision of Council of Ministers
FMHI	Fund for Mandatory Healthcare Insurance
GDP	Gross Domestic Product
HC	Health Center
KHC	Key Health Centers
MDGs	Millennium Development Goals
NDI	National Democracy Initiative
PHC	Primary Health Care
PHD	Public Health Directory
RHA	Regional Health Agency
RHD	Regional Health Directory
SBO	Statistical Based Observation
SHC	Satellite Health Centers (ambulance)
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development

Abstract

The main goal of this survey was the investigation of primary health care centers in Albania through a statistical selection of a number of them with a 3.6 % tolerance of error for primary health centers and 4.3 % for ambulatory centers. The survey aimed at engaging the Albanian citizens to carry out the survey as they are the principal stakeholders in high quality health care. The survey was based on a questionnaire and administered by 550 trained enumerators. The representative health centers were selected among the data received from the Ministry of Health and the Public Health Directorate in all twelve regions of Albania. All data was gathered within a single day and was processed with software specifically developed for this observation with thirteen operators stationed in Tirana to collect and enter the survey answers. This survey contains important data on the operation of primary health care centers, analysis of strengths and weaknesses of the primary health care system in Albania and recommendations for the Ministry of Health, the health centers themselves, the Mandatory Health Care Insurance Fund, and Albanian civil society organizations.

Main findings

- Approximately 85% of the primary health centers in the country are active. 10% of the sampled primary health centers are closed whereas approximately 5% are temporarily closed.
- Generally, Health Centers are following the proper opening procedures at a percentage of 85%. The primary health and ambulatory centers show similar results at 81% and 86%, respectively.
- Primary Health Centers in Albania are not equipped to provide services for disabled people in 95% of the centers. The infrastructure of Health Centers can be classified as 17% accessible for disabled persons, 38% as somewhat accessible for disabled persons, and 16% as inaccessible for disabled persons. Distributed according to the primary Health Centers and ambulatory centers, 46% of the main health centers have accessible infrastructure, 29% have somewhat accessible infrastructure for disabled persons, and 4% are classified as inaccessible for disabled persons.
- In general, all services are provided at Health Centers at national level in high percentages, of 95% and higher.
- Approximately 67% of Health Centers have a regular relationship with Fund for Mandatory Healthcare Insurance.
- Investments were generally in professional training at over 85% for the sampled Health Centers. Investments are higher and more significant in the primary Health Centers with 34% compared with 19% for ambulatory centers.
- More than half of the Health Centers are properly equipped with medical equipment, making for 57% of the sample.
- More than half of the centers are appropriately supplied with medications, specifically 54% of them. 75% of the Health Center medication supplies are at an adequate or somewhat adequate level.
- Health centers nationwide possess the appropriate documentation, with 80% of Health Centers having appropriate documentation and approximately 15% of with somewhat appropriate documentation. The lowest values for documentation found at the Health Centers are for the registers for recording urine and blood tests at

approximately 10% and 13%, respectively. The highest values are for the Main Register at over 90% and the Register for Recording visits of adults, at almost 90%.

- In general, nearly two-thirds of the health centers were closed at their scheduled times. In comparing data for the primary and satellite Health Centers, primary Health Centers show a higher level of closing at official hours with 88% and ambulatory centers at 71%.

Introduction

The Coalition for Free and Fair Elections and Sustainable Democracy (CFFESD) carried out an observation of Health Care Centers¹ throughout Albania through the voluntary engagement of Albanian citizens. The methodology used, known as Statistically Based Observation (SBO) is a powerful tool that enabled the organization to carry out a credible monitoring of health centers by comparing respective services provided in different health centers throughout Albania for the whole country and based on different regions. 550 stationary observers were deployed in 550 Health Centers, according to a representative sample for the entire country. Observers were present at health centers throughout the working hours of a health center and gathered relevant information that served for assessing their performance. The monitoring of the health centers was carried out in a single day on October 16th 2014. The statistical distribution made it possible for the results of the observation of services provided in the health centers which are presented under Chapter 5 of this Survey to represent all health centers and their branches throughout Albania. The observers were trained by the Project's technical staff and were fully prepared and responsible for the observation of critical aspects of the health centers' work and for gathering the necessary information. Information was gathered through a questionnaire drafted by the CFFESD social, medical and statistical experts in order for the conclusions and recommendations submitted to the Ministry of Health to be credible and with a small margin of error. Statistical data was processed with the statistical program SPSS 22.0, which allows for the aggregation and analysis of data with a high credibility coefficient. CFFESD publicly presented all activities organized throughout the lifecycle of the Project through press conferences and press releases. The Project was implemented with the support of the United States Agency for International Development (USAID) through Assist Impact.

1 Health Center in this survey means the Primary Health Care Centers that operate as primary and satellite centers or ambulatory and consultancy centers.

Chapter I

Literature Review

During the 20th century, the World Health Organization (WHO, 2008) has been at the forefront of work and guidelines that each country can provide primary healthcare as a public good guaranteed by the government. However, according to (WHO, 2008) it should not be the government alone that ensures a consolidated and progressive healthcare system, but responsibility must be shared with the local government structures, health professional organizations and civil society organizations. On the other hand, various studies are skeptical on the way how health institutions take responsibility (Davis, 1999). Studies show that the public does not trust the institutions as guarantees of equality, fairness and integrity in the health sector (Davis, 1999). The public expects from the health authorities to do their job well and diligently. (Gilson, 2003). People want their communities and environments to be safe and for their primary healthcare to be protected by the universal health approach and social protection (Sen, 1999). According to WHO (2008), governments are mainly responsible for shaping the national health systems, keeping in mind this does not mean that the health system requires frequent repairs in progress to improve. A significant role in this formatting should be played by the country's politicians, local governments, scientific research groups, the private sector, civil society and the global health community (WHO, 2008).

The term “primary health care” (PHC) was first used in 1978, after the International Conference on Primary Health Care by WHO and UNICEF at Alma-Ata. But, since that time PHC has taken different meanings at different times and among countries and groups (Rogers and Veale, 2003).

PHC according to the WHO (1978) as it is written in the Declaration of Alma-Ata is:

...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

Globalization has an effect on the health system as well and with regard to this WHO (2008) argues that the health system and societies are not managing to respond fast enough. This is reflected in the inability to mobilize the necessary resources and the right institutions to respond to rapid changes in the health system (WHO, 2008). Many world researchers note that in developing countries, the health system is fragmented and patients try to seek solutions for different health problems in various institutions (Masseria et al., 2009; Hofmarcher, et al., 2007; Lafortune and Balestat, 2007). A high level of service is required from PHC so that it is able to serve aging and growing population Very good coordination is required from the whole ambulatory service, hospitals and various clinics to ensure long-term health care at the appropriate cost. According to Masuria et al., (2009) this coordination is missing and since patients initially enter the health system from the primary care key (Hofmarcher et al. 2007), this brings about the absence of proper treatment or overlapping of diagnoses or treatments provided to patients.

Patients bring various problems to the primary health care system and this system often serves as a link through which patients are re-directed to various specialized health system sectors (Boerma, 2006; Masseria et al., 2009). For this reason, the primary health care system and the institutions where the service is provided need good investment to have all the necessary resources to detect diseases that require specialized treatment at early stages (OBSH, 2008).

Researchers say that the appropriate primary health care system can contribute substantially throughout the whole performance of the health system in a country (Starfield, Shi et al. 2005). Masseria et al (2009) provides the main characteristics of the primary health care system saying that this system should be focused on people, easily accessible and comprehensive. A large number of researchers have scientifically proven that continuous health care is also linked to low mortality rates (Shi, 2003; Franks, 1998; Villalbi,1999; PAHO, 2005). Good access to primary health care and an effective hospital system (Weinick, 2000; Forrest, 1998) means less hospitalized people, (Weinberger, 1996), less need for assistance by the specialized doctor (Woodward, 2004),less need for the use for emergency services (Gill, 2000), which all translate to less cost for a given country. Service in primary health care institutions, as regular entry points is crucial and affects patient satisfaction (Weiss, 1996; Rosenblatt, 1998; Freeman, 1997; Miller 2000). Different methodologies have been developed throughout the world to measure patient satisfaction. The most used one is called Service Quality (SERVQUAL) and it measures patient satisfaction through the Likert scale.

The ultimate goal of primary health care is better health service for all (WHO, 2014), thus, in this respect WHO (2014) has identified the key elements to achieving this goal:

- Significantly reduce social inequalities and exclusion of marginalized groups (universal coverage reforms in health);
- The organization of health services around people in need and according to expectations (service delivery reforms);
- Integrate health into all sectors (public policy reforms);
- Track collaborative models of policy dialogue (leadership reforms); and
- Increase participation of stakeholders.

Key actors in the primary health care

General practitioners are the main actors (BOERMA, 2007) in the primary health system. This system includes various levels of primary care, such as: pediatricians, opticians, dentist, gynecologists, other specialized doctors, nurses, midwives, pharmacists, physiotherapists (Masseria et al., 2009). The inclusion of these disciplines in primary health care varies in different countries and often determines the characteristics of the primary health care system (Masseria et al., 2009).

As highlighted by the Organization for Economic Cooperation and Development (OECD in Hofmarcher et al. 2007; Masseria et al. 2009), primary health care centers constitute the preferred system for providing primary care in many countries. General practitioners recommend patients to specialized outpatient service in 58% of European countries, and to the hospital services for more in-depth visits in 46% of the European countries (Hofmarcher et al. 2007). Very rarely do patients contact a specialized doctor without first going to the GP for a referral only in 4% of the cases in OECD countries (Masseria et al., 2009).

According to Masseria et al. (2009) states are divided into two major groups:

1. Countries like the Czech Republic, England, Finland, Italy, Lithuania, Netherlands, Romania, Slovakia, Slovenia, Spain, which require that the patient first visits the GP to get their recommendation and then they may continue in the health system on to higher and more specialized level.

2. Countries like Austria, Belgium, Denmark, Estonia, France, Germany, Poland and Sweden which use financial incentives to encourage patients to register with a doctor to get a recommendation and then continue on to the respective specialized doctor.

However different countries present different historical and cultural trends of the primary health system. In Sweden, patients tend to go directly to the specialist because of a historical model of access and lack of GPs (Masseria et al., 2009). Whereas, in Belgium the system allows the patient to choose among different specialists for the first health visit (Masseria et al., 2009). Recent reforms in Belgium, France and Germany encourage patients to get a recommendation from a specialist, thus reducing the fees for this service (Masseria et al., 2009). Recent reforms in Germany aim at encouraging patients to use as the GP as the first contact, but at present only 8% of patients have such a doctor in this country (Masseria et al, 2009). In the Czech Republic, even though patients should go to a general practitioner as their first contact, it seems possible to meet with the specialist without going through the GP first (Masseria et al, 2009).

The role of nurses in the primary health care system

The role of nurses is another quite important aspect of primary health care. Many countries such as Denmark, Poland, England, the Netherlands and Sweden are using the medical nursing service massively (Masseria et al, 2009). Nurses can care for patients with minor health problems such as prescribing certain medication and giving vaccines to teenagers. (Masseria et al, 2009).

Nurses are also involved in coordinating the path that should be followed by patients with chronic diseases such as in Belgium, Denmark, England, Finland, Poland, Slovenia and Sweden (Masseria et al, 2009). In some countries, clinics run by nurses used as an alternative method for patients who need ambulatory service after an acute phase of a disease (Masseria et al, 2009). Sweden is one of the European countries that has established clinics run by nurses that serve patients with chronic or long-term diseases, such as diabetes or heart disease. These clinics are becoming popular in other countries, as well such as Denmark, England, Estonia, France, Sweden and in two regions of Spain (Masseria et al, 2009).

Citizens at the center of the health policy dialogue

The center of the dialogue on good policies for primary health care should

be the participation of stakeholders. as countries develop, their citizens attribute more value to social responsibility and participation. According to Blank (1997) increased prosperity, intellectual skills and social ties are associated with increased aspirations of the people to give their opinion on what happens in their community. This leads to the indisputable importance of community participation in government decisions that directly affect their lives and one of these areas is the health care area, especially primary health care. PHC reforms require a broad dialogue to set the expectations of various stakeholders and have their voice heard. Health authorities and the Ministries of Health, which have a primary role in policy-making, need to unite their decision-making power with the community's rationality, scientific and professional commitment, as well as the value and resources of the civil society (Wasi, 2000, Amar, 2003). This is a process that requires time and effort.

Finally, the ideal model of primary health care as mentioned at the beginning of this chapter is quite clear in the Alma Ata Declaration and has become the basic concept for the World Health Organization under the slogan "Health for All".

Chapter 2

Primary Health Care in Albania

The Albanian Health System is mainly public. The State ensures the majority of the services offered to the people in the area of promotion, prevention, diagnosis and treatment. The private health sector is still taking its first steps with regard to primary care and covers the majority of the pharmaceutical and dentistry service, as well as a number of specialized diagnosis clinics mainly concentrated in Tirana.

Regardless of whether a citizen chooses the public or private system for his or her healthcare needs, the following patient rights are to be honored in that all patients are guaranteed the right to:

- Access to healthcare services
- Credible and personal care at health centers
- Information
- Referral for a more specialized visit, when needed
- Free choice of a family doctor once a year
- Ongoing care
- Participation in decision – making regarding his or her health
- Treatment received by qualified staff of doctors and nurses
- Rejection of health treatment
- Information on their health insurance plan
- Ability to provide positive and negative feedback on the healthcare provided

The primary role in the public sector is played by the Ministry of Health, which drafts and is responsible for the implementation of the health system policies and strategies that regulate its functioning and for the coordination of all actors within and outside the system. Diagnostic and curative health service is organized into three levels: primary care, secondary hospital care and tertiary hospital care.

Public health and promotion services are the basis of the Institute of Public Health activity, the only state institution subordinated to the Ministry of Health that offers better qualified expertise areas mentioned above. Apart from the above-mentioned institutions, a number of national institutions such as the National Center for Blood Transfusion; National Center for Child Upbringing, Development and Rehabilitation; University Dental Clinic National Center for Biomedical Engineering, National Center for Drug Control and the National Center of Quality Safety and Accreditation of Health Institutions.

With the exception of Tirana, where the primary healthcare is organized and functions based on the Regional Health Authority (RHA), in all other regions it is the Public Health Directorates (PHD) and Regional Health Directorates (RHDs) that function in all centers of the 12 regions.

Public Health Directorates and Regional Health Directorates coordinate all health services of primary healthcare in each region. There are Hospital Service Directorates in all regions and in the 12 main towns they are called Regional Hospital Directorates. Health Centers operate as autonomous units contracted for the health services offered through the mandatory scheme of health insurance and the Basic Primary Healthcare Service Package.

The Health Center (HC) is the primary health care institution that is publicly funded, non – for – profit and has its own bank account, that includes the network of all service providers as its subordinates and exercises its activity based on Law No. 10107, dated 30.03.2009 “On the primary health care in the Republic of Albania”, Law No. 10138 dated 11.05.2009 “On public health”, Law No. 7870, dated 13.10 1994 “ On the health insurances in the Republic of Albania”, as amended.

Based on Article 100 of the Constitution, point 2, Article 4 of Law No. 10107, dated 30.3.2009, “On the health care in the Republic of Albania”, as amended and Article 10 of Law No. 10383, dated 24.2.2011, “On the mandatory health care in the Republic of Albania, as amended, upon proposal of the Minister of Health and the Council of Ministers.

The Health Center implements the Albanian laws and sublegal laws issued by the Minister of Health, Local Health Authorities authorized by the Minister of Health and the Mandatory Healthcare Insurance Fund.

With regard to financing, the Health Centers have an annual budget funded by the Mandatory Healthcare Insurance Fund. The budget is used in three directions: to pay for staff salaries, utilities and medicine. Each Health Center generates secondary income from health care services offered for patients in the absence of a Health Booklet or health services against invoices. Secondary income is used to pay for investments, pending

approval by the management board, where they are first submitted as proposals. According to the interviewees, this process is usually lengthy or postponed due to subjective reasons. This has a direct impact on the quality of services and results in complaints by patients for the manager or the staff of the health center, since they are not aware of the primary role that the board plays on the progress of the health centers.

Health Institutions Hierarchy

The Ministry of Health is the institution responsible for the development of health policies and strategies in Albania. The Mandatory Health Insurance Fund is responsible for assigning funds to the Primary Healthcare Centers.

The Mandatory Healthcare Insurance Fund

Healthcare Insurance in the Republic of Albania is stipulated in Law No. 10383, dated 24.2.2011 “On mandatory healthcare insurance in the Republic of Albania”, as amended. The Healthcare Insurance Scheme has started implementation on 1 March 1995 as an important mechanism for the reformation of healthcare and improvement of the quality of offered services.

Public Health Institute

The highest technical institution in the area of public healthcare is the Public Health Institute, a national institution under the direct subordination of the Ministry of Health. Its main institution duties include: studying and monitoring of risk factors, surveillance of contagious diseases, lab reference and management of vaccination programs. The implementation of many short – term programs of research or promotional nature is also part of its activities. The Public Health Institute also plays an important role with regard to training in the area of public health.

National Center of Drug Control

The Center is the responsible institution for the control of any activity in the pharmaceutical area. It exercises its control over:

- Activity and production, premises and equipment
- Wholesale and retail and the conditions for storage of medicine

- Medical raw material and supporting package material
- Medicine imported by all the licensed subjects

National Center for Blood Transfusion

The National Center of Blood Transfusion aims at ensuring the gathering of blood and its products to optimally meet the needs for transfusions in treating individuals injured in accidents, severe and chronic anemia patients, cancer patients, patients to undergo surgical interventions, women who have severe case of bleeding during delivery etc. The National Center of Blood Transfusion composes of 29 Blood Banks, of which 3 are found in Tirana and 26 in the other regions.

National Center for Child Upbringing, Development and Rehabilitation in Tirana

The National Center for Child Upbringing, Development and Rehabilitation in Tirana was established in 2000 as a national diagnosis, curing and training center. Its mission is to improve the quality of the lives of special needs children and to make them partners in the long road towards their rehabilitation, care and education.

National Center for Biomedical Engineering

Its aim is prophylaxis and the maintenance of medical equipment with the goal of providing the best care to their patients by increasing the quality of their service as a combination of medical equipment used and the health institutions' staff (including medicine doctors, specialists, nurses, etc.).

National Center of Quality, Security and Accreditation of Health Institutions

This institution supports the Ministry of Health with the implementation of the long term National Health Strategy in the following areas:

- Continuous improvement of the quality of the health system;
- Drafting, distribution and preliminary monitoring of Clinical Guidelines (Clinical Protocols) with the best clinical practices to assist the medical staff;
- Accreditation of Albanian public and private health institutions;
- Therapeutic education and empowering the role of patients as main and central stakeholders of the health system;
- Minimizing risks and mistakes in the health institutions: Increasing security for patients and the medical staff;
- Creating, gathering and using scientific evidence proved to be the best medical practices.

University Dentistry Clinic

It operates based on a regulation and respective guidelines by the Ministry of Health. It offers specialized services in: maxillofacial surgery, therapy, orthopedics, pedodonty and provides professional training for doctors during their specialization training.

Helicopter Transport Unit

Their mission is to cover medical emergencies where the need presents itself for providing such a service. Their main activity includes the specialized medical transport by helicopter of patients in acute cases.

Governmental Health Care Clinic

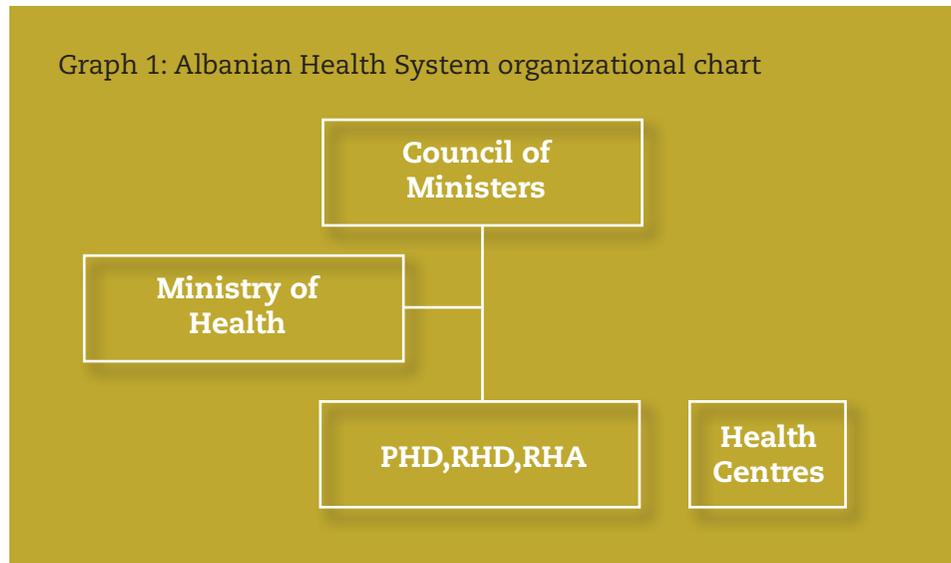
Their mission is to offer emergency and primary medical services for the senior state authorities. Its services: accompanying government delegations to enable provision of first medical aid in case of need.

National Center of Continuous Education

Their mission is to encourage, deliver and improve the professional training for all categories of professional staff with the aim of enhancing the knowledge and developing the skills of the medical staff.

Main activity: Drafting a national plan of actions for medical staff continuous training.

The primary health sector in Albania operates according to the hierarchy presented in the following graph:



Further on, Tirana Health Centers have their own ambulatory points (satellites), in order to be as close to the public as possible. The satellites are considered to be part of the health centers and not regarded separately. Administratively speaking, they are subordinate to the Regional Health Authority RHA, Tirana RHA and financially dependent on the Mandatory Health Insurance Fund and the Regional Healthcare Insurance Directorate.

Semi – structured interviews with the managers of Health Centers and managers of Primary Healthcare in different institutions clearly identified that relations between RHA and RHID, which are currently completely frozen and thus damage the progress of work, need re-establishment and actions need coordination. Also, the existence of the Health Center Boards poses difficulties in finding fast solutions to issues. The managers of the Health Centers say that they have to submit a request to the Board even for replacing missing or broken medical equipment. On the other hand, even though there is the “repair fund” as part of the Mandatory Health Insurance Fund, requests are often postponed or declined. Their complaints regard unnecessary bureaucracy, which only contribute to a slower work pace and falling short of offering the required healthcare to

the patient. Even in cases when there is a shortage of medicine before the end of the year, there is a need to wait for the new budget for the coming year, regardless of the need for such medicine. De jure, the directors of Health Centers have many competences, but in fact they do not exercise any power at all. According to the managers of the Health Centers, they have to be appointed by the Management Board, which again does not make any sense to them.

Principles of health care

“Health care” shall mean the entirety of measures and actions taken by the health care institutions, healthcare employees and citizens with the aim of improving the citizens’ overall physical, mental and social welfare.

Health care is guided by the following principles:

- The right for health care is a fundamental human right;
- Ensuring equal rights to health care, based on the non – discrimination principle;
- The health care system functions based on the service efficiency and quality, guaranteeing the security of the patient and impartiality of services;
- Participation of different actors: patients, consumers and citizens;
- Accountability.

How is primary health care ensured?

- The primary health care is ensured through a network of professionals and health institutions, based on the principles of family health care.
- The primary health care is organized in such a way that it enables each individual who is resident within the territory of the Republic of Albania to use the primary health care providers; the right to choose a primary health care contact and register at the selected contact of the primary health care provider.
- Primary health care is ensured without limitations deriving from the disease, age, gender, and economic situation of patient category. Primary health care meets the needs for basic medical treatment, nursing care, prevention and rehabilitation, when they

do not require treatment and examination techniques that are provided by the other levels of health care.

- The Minister of Health approves the regulations on the organization and functioning of primary health care institutions.

Health Centers' staff (including ambulances) comprises of managers, doctors, nurses, midwives and support staff. Thus, health care services are not provided in a single building, but through a network of health care providers. Family Medicine (FM) is the fundamental professional discipline around which Primary Health Care is developed. In exercising their specialty skills, the family doctors exercise their competencies in these three areas: clinical duties, communication with patients, and management of Health Center.

The services benefited are detailed in the Primary Health Care basic package and include:

- Care in natural disasters emergencies
- Care in cases of common emergencies
- Provision of uninterrupted (24/7) health care at the Health Centers.
- Provision of care at the Health Centers with interrupted services (8 hours daily)
- Provision of care outside the Health Centers
- Healthcare for children.
- Healthcare for women and reproductive health
- Healthcare for adults
- Healthcare for the elderly
- Mental healthcare
- Health promotion and education

Social Insurance

The Social Insurance system was established based on Law No. 7870, dated 13.10.1994 "On Health Insurances in the Republic of Albania". Since its establishment, it covers a list of basic reimbursable medications and

the payment of the family doctor in the public system.

The system gradually developed with the widening of the scope of services covered going from non – differentiated financing to payment of health care packages.

The Albanian Health Insurance model is a mixed one (Bismark and Beveridge), based on mandatory and voluntary contributions, and funding by the state budget.

The economically active population pays health insurances, whereas the state budget funds (from general taxation) cover the non – active population and categories “in need”, thus giving the solidary approach to the system.

The health insurance system is based on the single – payer model, thus the Compulsory Health Care Insurance Fund manages the scheme in line with national health care policies. The Compulsory Health Care Insurance Fund uses the health services payment methods to influence increasing access, prevention and improvement of the population health indicators.

Annual contracts with public and private providers of health services on the provision of health care packages make for the mechanism for the implementation of the health insurance scheme.

The health insurance scheme covers:

- Primary care (except from mental health community centers, public dental care, health care in schools);
- Hospital services (except from psychiatric hospitals); List of purchased medications that the patient would receive reimbursement

The mandatory health insurance funds mandatory insurance with healthcare packages including:

- Medical visits, examinations and treatment at the public primary health care centers and public hospitals;
- Approved Healthcare Packages at private hospitals
- Drugs, medical products and treatment offered by contracted healthcare providers.

Another health insurance mechanism is co – payment of health care services. Categories of people in need, such as veterans, pensioners, invalids are excluded from co – payments.

New public policies, such as the free basic medical check-ups for people between the ages of 40 and 65, aim to take steps towards universal coverage of the Albanian population.

Which principles is the Albanian Health Insurance scheme based on?

The mandatory health care insurance scheme aims at the medical coverage of the population through these principles:

- Mandatory and voluntary insurance;
- Solidarity; Equal access for all citizens;
- Efficiency and quality in funding health services;
- Free choice of the doctor;
- Partnership

Insurance scheme benefiting categories

Every citizen who pays contributions for health insurance themselves or paid for by the state is insured and benefits from the health insurance scheme.

The Health insurance booklet (health cards to be put in use soon) is the only document that certifies that the person is insured in the health insurance scheme.

Health centers are audited once a year by the Mandatory Health Care Insurance Fund and every 6 months by the Regional Health Care Insurance Directorate.

The Mandatory Health Care Insurance Fund receives its budget from the contributions of the active population and the state budget. Currently, contributions account for 22% of the Mandatory Health Care Insurance Fund and 78% is covered by the state budget. The total budget is managed by the Mandatory Health Care Insurance Fund, which is further allocated as:

- Budget for Health Centers;
- Budget for hospitals;
- Budget for reimbursement of medicines;
- Budget for private health care packages.

Meanwhile, the Mandatory Health Care Insurance Fund financially covers health centers regarding:

- Employee salaries and insurances
- Recurrent expenses: electricity, water and emergency materials and medicine

Box 1 – Field Case

Durrës Regional Health Directorate

The Health Center is managed by an appointed director. The Primary Health Care Sector is funded by the Mandatory Health Care Insurance Fund. The Compulsory Health Care Insurance Fund finances 18 Health Centers in Durres district. The Compulsory Health Care Insurance Fund budget for the health centers covers salaries and expenses, social and health contributions and purchase of goods and services. The calculation of Compulsory Health Care Insurance Fund is done based on the expenses of the previous year plus an additional 1-3%, since each year budget should increase due to price changes. Investments on maintenance and equipment are funded by secondary income. As a result, 60% of secondary income is used for maintenance and purchase of equipment, 10% is used for bonuses and 20% for goods and services. Infrastructural investments are funded only by the Ministry of Health.

The normal functioning of a Health Center requires its budget to meet the requests for salaries, expenses, social and health insurances and goods and services. With regard to the maximum budget, the representative of the Durres Regional Health Directorate believes that the difference is from the amount of the Compulsory Health Care Insurance Fund destined for goods and services

Access to primary healthcare

Each insured citizen has a first meeting at the health center they are registered at through their family doctor (selected voluntarily by them).

The services offered are detailed in the basic Primary Health Care package and include:

- Care for emergency situation
- Health care in child upbringing
- Health care for women and reproductive health
- Health care for adults
- Health care for the elderly
- Mental health care
- Health promotion and education

If the patient needs to be referred for specialized care, they are issued a recommendation and sent to the specialized satellite healthcare unit. If the patient is diagnosed within these two levels, the patient returns to the family doctor with prescribed medication by the specialized doctor. If not, they are then referred further to a hospital to address treatment needs at the tertiary hospital care of specialized services clinic at the Tirana University Hospital Center.

Referral system operation

Each citizen is registered at the family doctor within his or her administrative unit of residence (municipality or commune). Having presented the Health Booklet and certificate of residence, the family doctor refers them to the specialized doctor. If further qualified care is needed, the individual is referred to the regional hospital or Tirana University Hospital Center.

The uninsured individuals follow the same system, but they receive services against the tariffs displayed within the institution premises.

Prevention role of primary health care

It mainly focuses on the most spread morbidity nosology, as identified by the pathology epidemiological trend. Preventive measures regard the prevention of chronic hypertension, diabetes disease, chronic pulmonary diseases, cerebral vascular accidents, mental health and chronic renal insufficiency.

Apart from the general measures of preventive character as identified in the basic package provided by the family doctor, the Ministry of Health has made certain clinical guidelines and protocols on the main chronic diseases (hypertension, bronchial asthma, diabetes, osteoporosis, obesity, mental health diseases) available for the family doctors.

Another preventive measure, which all doctors are trained in, is the identification of domestic violence by the primary health care institutions.

Box 2 – Obstetric Primary Care

The obstetric clinics offer the following services:

- Early identification of pregnancy within the first trimester
- Examinations specified in protocols on continuous monitoring of pregnancy
- Provision of vitamin supplements for pregnant women

Box 3 – Pediatric service

The pediatric clinics offer the following services for children:

- Monitoring of physical development in height and weight.
- Promotion of breastfeeding
- Immunization according to the national vaccination calendar
- Prevention of iodine insufficiency by administering the iodine tablets.
- Prevention of iodine insufficiency by administering iodine tablets.

Box 4

The gynecological and reproductive health clinics offer the following services:

- Information and education on reproduction and sexual health (including, teenagers), with respect to gender differences
- Informing and educating on IST/HIV/AIDS and other reproductive system infections (including, teenagers)
- Informing and educating on domestic violence
- Informing and educating on the detection of cervical cancer
- Informing and educating women in menopause and men in andropause
- Informing and educating women on the procedures for breast self - examination
- Informing, educating and advising on prenatal care
- Informing, educating and advising on postnatal care
- Informing, educating and advising on the methods for family planning
- Providing health materials to all patients.

Box 5 - Community services

Ambulance transport (type B) or transport in case of emergency towards health centers that provide uninterrupted health care services;

- Transport plan for emergency cases towards health centers that provide non continuous health care services;
- Education on body temperature, acute diarrhea, burns, personal hygiene, food preparation and the environment.
- Education on taking care of a person with a chronic or terminal disease or on the deterioration of the physical condition of such individuals;
- Education on providing first aid in cases of emergency and on the transport to the nearest health institution;
- Information on preventing common accidents at home
- Information on safety rules for drivers and pedestrians.

Chapter 3

Project “Observation of Health Centers”

The Coalition for Free and Fair Election and Sustainable Democracy (CFFESD) incorporated statistical observation principles for monitoring of performances of health centers throughout Albania. The CFFESD will use the same methodology for future monitoring of public institutions and political processes in Albania. This report provides detailed information about the current state of the public health centers² throughout Albania. The tabulations and cross tabulations present the strengths and weaknesses of the sampled health centers. Broken down by survey sections, the questionnaire data links directly to the procedures and protocols regulating primary healthcare system set by the Ministry of Health. The recommendations deriving from the survey findings will ultimately determine health centers and regions, as well as aspects of primary healthcare service provision that require more investment and improvement.

The study is conducted on statistical methods, commonly known as Statistically Based Observation (SBO). This methodology is a powerful tool that allows the organization to confidently assess the performances of key health centers, their satellites (ambulance) and analyze services provided by both. In July 2014, CFFESD has started with the project with the financial support of the Assist Impact through the United States Agency for International Development (USAID) and technical assistance of the National Democratic Institute (NDI).

The overall goal of the project is to improve citizen’s ability to receive proper medical services from primary health centers. Specific objectives are as follows:

- Conduct comprehensive analysis of functioning of the health centers throughout Albania.
- Work with national and local level decision makers towards improvement of health centers functioning.
- Publish the findings and recommendations.

2 For the purpose of this report, primary health centers include key health centers and satellite health centers.

In accordance with the existing Ministry of Health protocols and strategic documents, the research team identified specific research questions related to the performance of key and ambulance health centers, ultimately answering the questions as to whether the current primary health system is serving the population effectively and efficiently.

The key questions of this study related to the programming goals are as follows:

- What are the strengths and weaknesses of primary health centers? What characterizes a strong or weak primary health center?
- What areas of investment could be considered most effective?
- In particular, which regions and cities in Albania have the most need for improvement?

The report provides the Ministry of Health and the Fund for Mandatory Healthcare Insurance (FMHI) with recommendations and conclusions on each of these questions in order to be considered in designing future policies and decisions in primary healthcare, including, but not limited to, decisions on distribution of budgetary funding.

To accomplish the monitoring of primary healthcare system, the CFFESD relied on a series of documents, strategies, legal acts and regulations governing the functioning of primary health care in Albania. These documents were used as the basis for developing the questionnaire, which served as a basic tool for monitoring of performance of primary health care centers, as well as the manual, which was used in the training of the field monitors.

The basic legal documentation that was used to design the questionnaire and reporting is as listed below:

- The Basic Package of Primary Health Care Services, adopted in January 2009;
- Quality Standards for the Accreditation of Institutions of Primary Health Care, adopted in February 2009;
- Decision of Council Ministers (DCM) No. 857, dated December 20, 2006, “On the Financing of Primary Health Care Services by the Compulsory Health Insurance Scheme;
- Regulation of the Board of the Health Center Directorate of Public

Health and Regional Health Agency Regulation;

- General Contracting Services for Primary Health Care;
- Statute of Health Centers;
- No. 559 Order dated October 26, 2009, for application fees of medical services for patients, according to the “Schedule of Fees for Medical Services for Patients in Primary Health Care and Specialized Hospitals.”
- Order No. 526 dated December 10, 2009, “On the Implementation of the Referral System in the Health of Patients.”
- Order No. 49 dated November 2, 2011, for the approval of the regulation “On the Organization and Functioning of Medical Laboratories.”
- The Strategy of Public Health and Health Promotion: “Towards a Healthy Country with Healthy People” –from the Health Reform Project in Albania, USAID, and the Ministry of Health, add the year
- Albanian Charter on the Rights of Patients;
- Instruction on Clinical Practice in Primary Health Care.
- List of equipment in the Health Center (minimal standards on physical infrastructure and Standard List of Medical Equipment), according to DCM nr.857, dated 20/12/2006, (amended).
- List of Medication and consumption goods in the Health Center, according to DCM nr.857, dated 20/12/2006, (amended).
- List of Medical Documentation in the Health Center, approved by the Ministry of Health.

A health center is the basic unit of the primary health service provision in Albania. It is a non-profit publicly funded institution with a separate bank account. The health centers include all network service providers (ambulances) and exist under the following laws and regulations:

- Law no.10107, dated March 30, 2009, “On Health Care in the Republic of Albania”;
- Law no.10138 dated May 5, 2009, “For Public Health”; amended law number 7870 dated October 13, 1994, “On Health Insurance in the Republic of Albania”;

- DC amended number 857, dated December 20, 2006, “On the Contraction of Primary Health Care Services and the General Rules for Contracting Primary Health Care Services.”

Health centers implement Albanian legal regulatory framework issued by the Ministry of Health, local health authorities (Regional Directorates of Health) authorized by the Minister of Health and the Fund for Mandatory Healthcare Insurance.

The health center provides primary health care services under the basic package of primary health care services. Health centers can also provide specialized outpatient care outside the basic package of primary health care services, contracted by the Fund of Healthcare Insurance. All health centers are to carry out the regulations and laws approved by the Minister of Health.

Primary healthcare is provided to the Albanian population by the its basic unit, known as the key Health Center (kHC), at the level of towns and centers of communes, and by some satellite Health Centers (sHC), known as ambulances, at the level of villages, with the intention to provide for widest coverage and access of the population to primary healthcare, it being the first contact point of the national healthcare system.

For the purpose of the study, to analyze the functioning of the primary health care system in all of its components, CFFESD received information from the Ministry of Health on the total number of health centers. There are 415 key health centers contracted by the Fund of Health Insurance. Under the jurisdiction of these key health centers, there are the remaining 1801 satellite health centers, i.e. ambulances or healthcare points.

Through direct contact with the Regional Health Directorates in all regions of the country, CFFESD confirmed active or inactive status of all health centers, correct addresses, distance from the center of the municipality or city, and reporting relationships between the two levels of the system.

The personnel of health centers (including satellite health centers) consist of managers, doctors, nurses, midwives and support staff. Health care services are not always offered in a single building, rather through a network of providers of health services (ambulances and healthcare points). A key health center covers all basic primary health services, including: emergency care, health care for children, women and reproductive health, health care for adults, and the elderly, mental health care, and health promotion and education.

At the district level, the primary healthcare system is run by the Regional Directorate of Health and the Directorate of Public Health. In the district of Tirana, the system is directed by the Regional Health Authority, which

administers key health centers at the city and commune level, as well as Specialty Polyclinics.

According to the Basic Package of Primary Healthcare Services, each municipality must have at least one key Healthcare Centre, and every village should have an ambulance, which is served by at least one nurse. On average, at the national level, each health center covers a population of 8000 to 10,000 people. This figure fluctuates significantly between urban and rural areas, having a doctor/patient ratio of 1/2500 and nurse/ patient ratio of 1/400.

In view of the primary healthcare system and macroeconomic factors of the country, it is clear that a small part of the state budget goes to investment in healthcare. Primary care, especially, is under 4% of the entire budget for 2013, with values for 2014's budget not far from this value. Table 1 below shows some basic macroeconomic data and the budgetary expenditure related to health services in Albania.

Table 1: Macroeconomic factors, 2013 (in USD)

GDP ³	\$12.90 billions
GDP/per capita	\$4,650
Population ⁴	2,898,782
Budget expenditures ⁵	\$2.4 billions
Health care	10.99%
Primary	3.72%
Secondary	6.23%
Public health	0.95%

Historically, Albania has been on the lower end of health expenditure as a percentage of Gross Domestic Product (GDP) as a whole. Table 2 below presents regional statistics for health expenditures of countries in the region as a percentage of GDP in 2012. Clearly, Albania has a lower percentage of GDP in comparison to its neighbors, with Albania at almost 6% and others 7% and higher.

3 GDP values from World Bank Data http://data.worldbank.org/country/albania#cp_wdi

4 From INSTAT 2013 Data

5 Budgetary Expenditure values from the Albanian Ministry of Finance 2013 Budget Information, conversion rate used 107 Leke to 1 USD

Table 2: Total expenditure on health as % of PBB, 2012⁶

Albania	5.97
Bosnia and Herzegovina	9.89
Croatia	6.82
Greece	9.27
Italy	9.17
Macedonia	7.13
Montenegro	7.57
Serbia	10.47

6 All values from http://apps.who.int/nha/database/World_Map/Index/en?id=REPORT_4_WORLD_MAPS&mapType=3&ws=0

Chapter 4

Methodology

The findings of this report are based on a one-day monitoring effort held on October 16th, 2014. On this day, CFFESD deployed 550 stationary monitors on the representative sample of health centers and their satellites throughout Albania. Observers were present at the deployed location for the entire day during the working hours of the health center and/or satellite center and collected relevant information that allowed CFFESD to evaluate the performances of health centers and satellites. By deploying observers to a representative, random sample of health centers and their satellites, CFFESD made precise assessment of their performances. The sampling methodology used (random, nationally-representative stratified sample) allows for findings to be extrapolated performance of health centers and their satellites throughout the country.

The project, which started in July 2014, went through a series of phases, including: analysis of primary healthcare regulatory framework, consultation with Ministry of Health on list of primary health care providers, questionnaire drafting and finalization, recruitment of observers and coordinators, training, setting up of communication and reporting infrastructure, database creation, data collection, and data analysis.

Nearly six hundred women and men were engaged throughout the program, as volunteer observers, direct beneficiaries, experts and the coalition managing team. This includes 550 observers, 5 team leaders, 30 experts, 30 call center operators, 10 local coordinators and 12 representatives of organizations in each 12 districts of Albania.

Questionnaire Design and Testing

The questionnaire was drafted by CFFESD in English and Albanian languages. It was then back translated from Albanian to English and checked by experts at CFFESD.

Pre-testing was completed before fieldwork was done in September 2014 and before the field monitors training. This was done to ensure that the wording of the questionnaire was clear and free from respondent misunderstandings. In total, 9 Tirana health centers – 4 key and 5 satellite health centers – participated in the pre-testing. None of these respondent

answers were included in the analyses. The results from the pre-testing were only used to improve the survey instrument. The questionnaire was finalized by CFFESD on the week before the observation date in October 2014.

Based on the legal framework for the establishment and operation of primary health care units, listed in previous chapter, the main sections of the survey are as follows:

The main sections of the survey are as follows:

- **General Data:** This includes questions about basic contact and operating information on the health center, its classification of whether it is a KHC or SHC, the type of care it is prepared to provide, and accessibility characteristics.
- **Administrative Information:** This section is completed by the director or person in charge of the health center and asks financial information as well as auditing and reporting requirements.
- **Personnel:** This table is also complete with information from the director or person in charge. Its focus is to itemize the professional and administrative staff of the health center.
- **Primary Health Care Center Infrastructure:** The questions in this section ask about basic infrastructural characteristics of the health center like electricity, water, garbage collection, examination rooms, and basic equipment.
- **Primary Health Care Center Equipment:** This detailed section is organized as a “yes” or “no” checklist for equipment at the health center such as thermometers, stethoscopes, and gynecological instruments.
- **Primary Health Care Center Inventory Check List:** Similar to the equipment checklist, this section asks the health center staff about the stock of medicines in the health center.
- **List of Documents in the Primary Health Care Center:** These questions are also organized like the checklists above with a focus on appropriate documentation that the health center should have on the premises.
- **Closing Procedures of the Health Centers:** This section asks about the open and close time of the health center as well as the number of patients served for that day of monitoring.
- **Patient Satisfaction:** The information in this survey will be collected

for 1 man and 1 woman patient on the premises of the health center the day of monitoring. Basic demographic data, details on the type of service received, and opinions on their experiences in the health center are collected. This is the only section of the survey in which the data is collected at the patient level while all the other sections are collected on the health center level.

Sampling Methodology

In Albania there is total of 2215 Health Centers out of which 415 are clinics (Key Health centers) and 1801 are ambulances (Satellite Health Centers under jurisdiction of clinics). Health centers are grouped in 12 “quarks,” which are defined as general administrative divisions in Albania.

Researching services provided to the public by the Health Centers CFFESD concluded that clinics are providing services of ambulances but also are providing additional services according to the direction of the Ministry of Health Care. Therefore, CFFESD concluded that Health Center research project should have statistically sound data on several levels:

1. Nationwide level representation of the ambulance performances regardless whether services are provided by clinics or ambulances
2. Ambulance performances on level of clinics
3. Ambulance performances on a level of isolated ambulances
4. Ability to compare ambulance performances in between ambulances in clinics and those outside of the clinics
5. Ability to evaluate performances of other services provided by the clinics.

Based on Theory of Large Numbers and Central Limit Theorem in order to have statistically sound sample of any universe of units sample has to be random and representative. In order to secure proper representation of the sample, CFFESD used 12 quarks for stratification, while for random selection of health centers within the strata CFFESD used type of probability sampling called systematic sampling in which each unit in the total population has an equal chance to be selected forth sample. In this way, the starting point for sample collection was selected randomly and step k was used to select every next sample unit. The value of k is equal to the total number of universe units divided by the sample size of sample units.

In order to secure above stated levels of sample relevance, CFFESD decided to oversample clinics and under sample ambulance service clinics from their natural proportion. Therefore, CFFESD sample consisted of 200 clinics which were random and representative on a level of clinics nationwide and still was large enough to evaluate all clinic performance. The sample also consisted of 350 ambulance services outside of clinics. These units were randomly selected and representative on a level of clinics nationwide. The ratio mentioned above for k used in case of clinics was 2.07, while for ambulances was 5.15.

On a level of relevance from 2 to 5, CFFESD used simple frequencies to calculate percentages per question. On a first level of relevance for the nationwide level representation of the ambulance performances, CFFESD used a weighting system to secure proper proportion within information obtained from clinics and isolated ambulances. The weight for clinics was 0.514 while for ambulances was 1.278.

Table 3. Sample calculation

No.	District	No. of HC	% of HC	No. of key HC	% of key HC	Sample K HC	K %	No. of satellites	% of Satellites	SAMPLE Satellites	SS %
1	Berat	160	7.22%	23	5.56%	11	5.50%	137	7.61%	27	7.71%
2	Dibër	113	5.10%	34	8.21%	16	8.00%	79	4.39%	15	4.29%
3	Durrës	123	5.55%	26	6.28%	13	6.50%	97	5.39%	19	5.43%
4	Elbasan	336	15.17%	53	12.80%	25	12.50%	283	15.71%	55	15.71%
5	Fier	255	11.51%	45	10.87%	22	11.00%	210	11.66%	41	11.71%
6	Gjiro-kastër	204	9.21%	31	7.49%	15	7.50%	173	9.61%	34	9.71%
7	Korçë	223	10.07%	39	9.42%	19	9.50%	184	10.22%	36	10.29%
8	Kukës	160	7.22%	27	6.52%	13	6.50%	133	7.38%	26	7.43%
9	Lezhë	162	7.31%	22	5.31%	11	5.50%	140	7.77%	27	7.71%
10	Shkodër	178	8.04%	37	8.94%	18	9.00%	141	7.83%	27	7.71%
11	Tiranë	101	4.56%	47	11.35%	23	11.50%	54	3.00%	10	2.86%
12	Vlorë	200	9.03%	30	7.25%	14	7.00%	170	9.44%	33	9.43%
		2215		414		200		1801		350	

Data Processing

Assess the Internal Consistency and Analyze the Items

CFFESD designed its questionnaire based on the Ministry of Healthcare requirements for health centers. Due to a large number of requirements, in its data analysis CFFESD grouped questions that refer to same aspects and designed scales that are measuring quality of the health centers performances per particular aspect. Each of these scales created are described below in the analysis section. However, CFFESD also looked for extremes per aspect, comparison in between clinics and ambulance services, as well as geographical relation in terms of identified problems in order to understand whether particular findings are nationwide trend or is related to some specific characteristic of the health center.

Internal consistency is preserved through the design of questions where all the questions have option to be filled in by interviewer, including the option “don’t know/don’t want to say.” Such an approach will secure not having missing data in the database which will allow equal approach in data processing for each of the questions. Moreover, to assure that interviewers will do their job properly, they will be asked to collect contact information of the respondents. Upon completion of the research CFFESD will use those phone numbers to randomly select 20% of respondents (around 110) to call them and ensure true participation in the research.

Moreover, in the questionnaire there are questions that are logically connected and answer on one question influences answer on the other question (e.g. question 1.24 Is there a receptionist at the HC? and 1.21

Who was present at the time of HC opening? or 1.25 Does the HC have a telephone number and its proper appliance at the reception? and 1.26

Is the telephone number visible at the center’s entrance? etc.). With this approach CFFESD envisioned to make sure there is no illogical answers within questionnaires’ and eliminate chance to have false data being processed. Estimate of the internal consistency was planned to be evaluated through Cronbach’s alpha, a statistic calculated from the pairwise correlations between items and Coefficient omega.

Assess the External Reliability and Validity

The validity of the scale will be measured taking into consideration the extent to which a scale actually measures what it is supposed to measure (McDonell, 2014). CFFESD validated the questionnaire to be used taking into consideration the apparent validity: face and content

validity (McDonell, 2014). Construction of the scale avoided questions in which observer judgment might interfere in the answers. The process of developing and validating an instrument is in large part focused on reducing error in the measurement process (Kimberlin&Winterstein, 2008). Convergent validity will be used for aspects of validity estimating the degree to which a measure is correlated with other measures that it is theoretically predicted to correlate with.

The reliability is checked with Likert-type scales using Cronbach's Alpha (internal consistency) and Spearman-Brown split half coefficient. According to Kimberlin and Winterstein (2008) perhaps the most widely used method for estimating internal consistency reliability is Cronbach's alpha. In general, values should be 0.7 and larger keeping in mind that the ceiling is 1.0 for good internal consistency. According to Kimberlin and Winterstein(2008), internal consistency gives an estimate of the equivalence of sets of items from the same test which in this case are the questions aimed at assessing quality of service in the primary health care service in Albania. The coefficient of internal consistency provides an estimate of the reliability of measurement and is based on the assumption that items measuring the same construct should correlate (Kimberlin&Winterstein, 2008). Internal consistency examines the relationships among the items making up the set, typically Cronbach's alpha (McDonell, 2014). Calculating Margin of Error for each individual question would be another indicator of reliability and how much it differs from the Margin of Error from maximum variance for that sample size.

The key survey questions used in the cross tabulations are shown below in Chapter 5.

Observer Training

570 observers were trained to observe the most important aspects of the health and ambulatory centers' performance and gather important data based on the questionnaire. Prior to observer training, CFFESD experts trained the trainers and local coordinators. These trainings aimed at preparing a Team of Observers with the necessary knowledge for carrying out the observation.

The topics addressed during the training dealt included: local observation, what it is and how it functions; methodology to be used for the observation of health centers; observation responsibilities and deadlines; information on the administrative and legal operation of health centers, their activities and the rights of the patient. Further on, they were trained on how to carry out the observation and how to fill in the questionnaire. They were

also trained on how to get present themselves at the health center and how to fill in the Complaint Form and the Critical Incidents

Form. Trainings were based on the Manual developed specifically for this observation titled “Observation of Primary Health Care Centers”, prepared by the CFFESD Team.

Training of Communication Center operators

CFFESD hired and trained 30 operators that worked at the Communication Center set up for the Simulation and Monitoring Day. Three training sessions were delivered. The first training was delivered on October 13th, on Simulation Day. The second training was delivered on Monitoring Day on October 16th and the last training was on October 17th, 2014.

Simulation Day

Simulation day was on October 13th, 2014. It consisted of a day to test the following issues:

1. To test the computer system data entry;
2. To verify observers and their contact numbers;
3. To verify the group of observers commitment regarded the work on the monitoring day;
4. To identify potential problems and concerns of observers who have been localized in the entire country, on the eve of the monitoring process;
5. To verify if the observers have already taken the right personal codes and informing them if not;
6. To verify the knowledge of observers on specific aspects of the work during monitoring day.

At the conclusion of this trial, some results and lessons for CFFESD team were noted. The computer system of data analysis showed that:

- It was noticed that 6 health centers that were in the sample did not physically exist, which based on Ministry of Health’s arguments happens because some of health center’s statuses are “not in

function,” but are not replaced in the lists of the Ministry since a decision has not been taken to close them down or reconstruct them.

- There was no feedback from 16 observers or 2.9% of the total number of observers.. In 8 of the cases, the observers were not reachable because in the zones where they live there is sometimes lack of a mobile signal. Later, though, the team was successful in reaching the 8 observers. The other 8 cases were not problematic either. The reasons were related to lack of possibility to answer in that specific moment due to other engagements, missing a number in their contact information, or minor technical problems.
- As far as questions answered by the observers on simulation day, there was no response in one or two questions out of around 12 questions prepared for this day from 66 observers. These questions were related to Observers’ Code and Local coordinators’ name which they couldn’t remember at the calling moment. In each case, the Call Center Operators reminded them of and clarified every unknown information.
- In other specific cases, observers who refused to monitor on the monitoring day for different objective reasons, such as personal or serious health problems of close relatives, were replaced after the simulation day was complete.

CFFESD successfully solved some of these problems within the simulation period or day. The simulation day, in general terms, was evaluated as very good by CFFESD statistics experts.

Communication and Reporting System

The information was transmitted to CFFESD’s communications center in Tirana through cell phone communication between the call center operator and the observer. Each observation was entered into a specially designed database that allows CFFESD to easily aggregate and analyze the data.

Sampling

The goal of this study is to analyze the functioning of the primary health care system and all its components. CFFESD received information from the Ministry of Health for the 2,216 total public health centers in Albania. There

are 415 key health centers contracted by the Fund of Health Insurance. Under the jurisdiction of these key health centers, there are the remaining 1801 satellite health centers, i.e. ambulances or healthcare points. These numbers were confirmed through direct contact with the Regional Health Directorates in all regions of the country, CFFESD confirmed active or inactive status of all health centers, correct addresses, distance from the center of the municipality or city, and reporting relationships between the two levels of the system.

CFFESD then collected data on health centers in the 12 districts in Albania. In total, the sample represents 25% of the public health centers in the country. Listed below in Table 4 with the total number of health centers and the sample size:

Table 4. Sampled districts

	District	Total Districts	Monitored Districts
1	Berat	160	38
2	Diber	113	31
3	Korçe	223	55
4	Shkoder	179	46
5	Gjirokaster	204	48
6	Durres	123	32
7	Tirane	101	33
8	Lezhe	162	37
9	Kukes	160	39
10	Fier	255	63
11	Vlore	200	48
12	Elbasan	336	80
	Total	2216	550

These districts can be aggregated into three regions: North region, Central, and South region. The North region cities include Diber, Kukes, Lezhe, Shkoder; Central cities include Durres, Elbasan, Tirana; and, South region cities include Berat, Fier, Gjirokaster, Korçe, and Vlore. Out of the 550 health centers included in this evaluation, 200 of these classified as key health centers and 350 of these as satellite health centers. Regionally, the health centers numbers are shown in Table 5.

Table 5: Sample composition by region

	Key Health Centers	Satellite Health Centers	Total
North region <i>Diber, Kukes, Lezhe, Shkoder</i>	57	96	153
Center <i>Durres, Elbasan, Tirana</i>	61	84	145
South region <i>Berat, Fier, Gjirokaster, Korce, Vlore</i>	82	170	252
Total	200	350	550

The confidence level of the methodology applied for health-centers by the end of the survey research was 95%, which is a very high level. Statisticians accept a 95% level of confidence across the world as an acceptable standard, so there should be high confidence in CFFESD's findings. Based on the theory of large numbers and central limit theorem, as fundamentals for sampling, observing health-centers and their branches on random and representative sample CFFESD will extrapolate collected information to all health-centers in Albania. The Margin of Error on the level of Key HC is 3.6%, on a level of satellites is 4.3% and on a nationwide level is 3.1%. When calculated individually per questions the Margin of Error does not oscillate for more than +/- 0.1%. As previously mentioned, these results can be extrapolated to all health centers in Albania. It should be noted that the extrapolation can be done on the health center level.

Limitations

Like in every survey there are inevitable limitations, detailed below. However the researching team believes that these limitations do not distort the findings of the survey and do not have a negative impact on the recommendations drawn as the final conclusions of the survey.

- Although CFFESD invested substantial resources into testing the readiness for training and testing of the observers for monitoring the health centers, very few CFFESD observers are trained health care professionals. Thus, it was likely that the CFFESD observers would not be able to identify some of the shortcomings related to the specifics of medical treatment and medications recommended.

- However, the purpose of this questionnaire is to assess whether health centers uphold the Ministry of Health – set standards for guaranteeing health care services as described in the official protocols and regulations. As a result, the training of observers on the content of these documents enabled the gathering of credible data.
- This survey lasted for only one day and could not evaluate the overall performance of health care centers and their quality in the long term. Instead, it provides a picture of the quality and services provided at the Albanian health care centers on a randomly selected day.
- The volume of visits to patients in health centers differs throughout the day and the number of visits differs from one health center to the other. The selection of patients for the survey foresees interviews with a woman and a man who used the health services center on the day of the survey, regardless of any other demographic quotas. Also, the number of interviews with patients does not change according to the number of patients at a specific health center. Consequently, the information collected in this area would not reflect the perception of all Albanian patients. Due to this limitation, this survey will consider the information collected randomly and will not try to extrapolate this information to all the Albanian people.
- Health care center facilities in Albania Ban esh may consist of a room, several different floors or different buildings. CFFESD sent only one observer to each health center, due to funding constraints. Consequently, it is admitted that for the bigger health centers, the observation of the full spectrum of services offered was difficult.

Chapter 5

Detailed Analyses and Findings

All information about procedural details is based on the Basic Package of Primary Health Care Services and Quality Standards for the Accreditation of Institutions of Primary Health Care, approved by the Ministry of Health. The regional directors of health and public health are in charge of implementation of certain procedures, such as necessary equipment and inventory. The information below is based on tabulations of general standards.

Each tabulation is done sample wide then by health center type, where applicable. Additional cross tabulations are performed by region of North, Central, and South then by district. If the variable is created from a combination of survey questions, data for the survey questions are shown to find extreme values. Some variables created from large survey sections, like the inventory measures that include over 40 items, do not have all items listed but rather describes the extreme values found. All of these different tabulations provided are in an effort to answer the research questions described in Chapter 3 and the final conclusions made are summarized in Chapter 6.

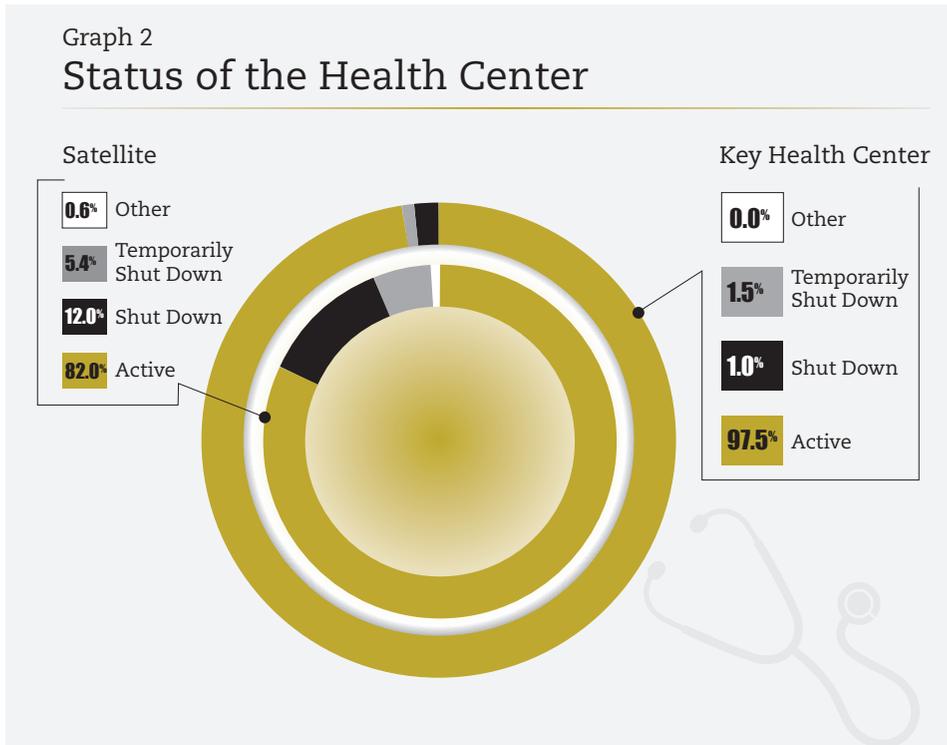
5.1 Status of the Health Center

The status of the health center in Albania according to the Ministry of Health is: Active, Temporarily Shut Down, or Shut Down. Observations are based on this status reported by the observers.

The questionnaire asked about the operational status of the sampled health center and was to be observed by monitor on site. The tabulations based on the entire sample are shown in Table 6 and the cross tabulation by health center type is shown in Graph 2.

Table 6

	Percentage
Active	84.9
Shut Down	10.0
Temporarily Shut Down	4.7
Other	0.5



Based on CFFESD observation findings, close to 85% of health centers nationwide are in operation with 10% of all sampled health centers closed while 5% are temporarily closed.

However, the situation is different when comparing key and satellite health centers. While with the key health centers close to 98% are operational, the situation with the satellite centers is much worse in their operations. Close to 18% of the satellite health centers were not functioning and 12% are closed and 6% are temporarily closed.

The regional data shows similar results to the nationwide totals with the majority of health centers as active. The central region shows high percentages of “Active” centers as seen in Table 7 below.

When looking to the details of the central districts in Table 8 only Tirana shows the highest value out of all the districts sampled. The North region and South region categories have districts with more than triple the count of centers categorized as “Shut Down.” Breaking this information further into district, Gjirokaster, Korce, Kukes, Lezhe, and Vlore all have the highest percentage of shut down centers all above 10 percent of the

total sampled in that district. It should be noted, also, that Vlore has the highest percentage of centers that are classified as “Temporarily Shut Down” with these centers comprising almost 17% of the district sampled centers.

Table 7

	North	Center	South	Total
Active	86.2	95.1	86.9	480
Shut Down	9.9	2.8	8.5	40
Temporarily Shut Down	3.9	2.1	3.3	17
Other	0.0	0.0	1.2	3

Table 8

	Active	Shut Down	Temporarily Shut Down	Other	Total
North region					
Diber	93.6	3.2	3.2	0.0	31
Kukes	81.6	13.2	5.3	0.0	38
Lezhe	81.1	13.5	5.4	0.0	38
Shkoder	89.3	8.7	2.2	0.0	46
Middle Region					
Durres	93.3	6.7	0.0	0.0	30
Elbasan	93.7	2.5	3.8	0.0	79
Tirana	100.0	0.0	0.0	0.0	33
South region					
Berat	97.4	2.6	0.0	0.0	38
Fier	96.7	2.5	3.8	0.0	61
Gjirokaster	78.3	17.4	0.0	4.4	46
Korce	88.7	9.43	0.0	1.9	53
Vlore	72.9	10.4	16.7	0.0	48

5.2 Health Center Setup

The questions for the health center set up is based on the standards developed, observed and applicable by the National Centre for Accreditation, Security and Quality of Health Institutions in Albania, an institution under the Ministry of Health.

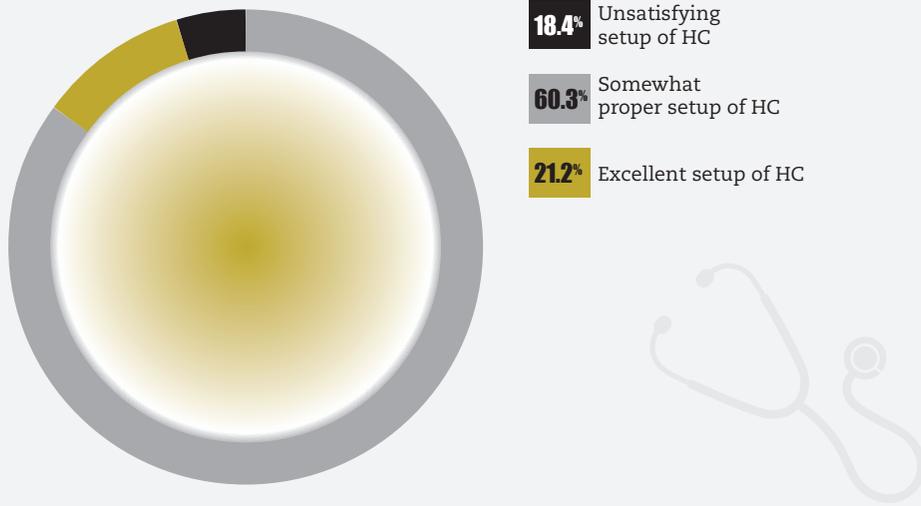
A new variable called HC Setup was created from a combination of survey questions related to the setup of the health center. All answers to these questions are “yes” or “no” with a summation of the “yes” answers creating the new variable. 1 or 2 is considered unsatisfying setup, 3 or

4 is somewhat proper setup, and 5 or 6 indicate an excellent setup. The questions used are listed below:

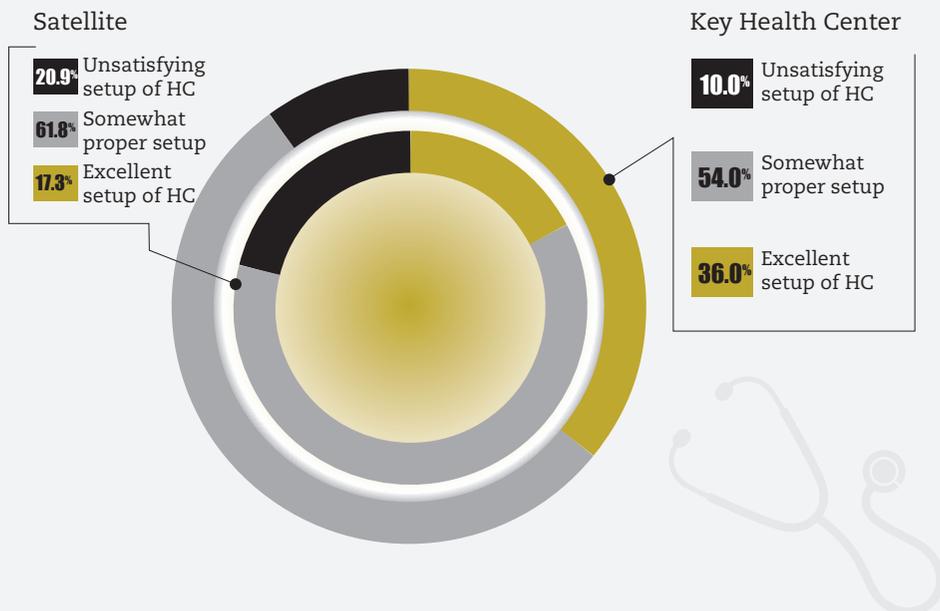
1. Is there a sign with the name of the health center at the facility's entrance?
2. Is the timetable exposed at the health center entrance?
3. Is there are receptionist at the health center?
4. How the health center has a telephone number and its proper appliance at the reception?
5. Is the telephone number visible at the center's entrance?
6. Are the service fees visible in the health center?

The tabulations based on the entire sample are shown in Graph 3 and the cross tabulations by health center type are shown in Graph 4.

Graph 3
Health Center Setup



Graph 4
Health Center Setup



Overall, the health centers are classified as somewhat proper in their setup at 65% nationwide. The health centers have similar percentages for the extremes of the classification with 16.5% classified as excellent set up and 18% considered with unsatisfying setup.



Looking to the cross tabulations by key and satellite health centers, the situation seems to be similar with the somewhat proper set up at approximately 63% and 66%, respectively. It is seen that the key health centers have higher frequencies of excellent set up with 29% compared to the 13% of the satellite health centers. For the unsatisfying classification, the satellite health centers have a much higher frequency of about 21% compared to the almost 8% of the key health centers.

Table 9 below shows the “yes” percentages for each question that comprises the scale of the variable HC Setup. For the individual questions that comprise this scale, the largest issue seen among all health centers sampled is not having a timetable posted at the entrance. Closely running behind this is whether a sign with the name of the health center is shown at the center entrance. Health centers sampled seem to have the fewest issues with having a proper telephone number and with the number visible at the center’s entrance.

Table 9

	Percent / Yes
1. Is there a sign with the name of the health center at the facility’s entrance?	73.5
2. Is the timetable exposed at the health center entrance?	80.0
3. Is there are receptionist at the health center?	25.2
4. How the health center has a telephone number and its proper appliance at the reception?	19.8
5. Is the telephone number visible at the center’s entrance?	27.1
6. Are the service fees visible in the health center?	61.7

In Table 10 below, the data is divided among the regions sampled while Table 11 presents the same data by district.

The regional data imitates the nationwide data with slightly higher percentages of “Excellent setup HC” found in the Centre and South region. The deviations from the regional data are seen in the “Unsatisfying setup of HC” classification with more than 50% of sampled health centers falling under this category for the central region. The second highest percentage of almost 30% is found in the North region.

The districts with the highest percentages of “Excellent setup of HC” are found in Tirana with 45.5% and in Korce with 40.4 percent. The lowest values are found in the North region with percentages all less than 14% for Diber, Kukes, and Lezhe. Two of these districts, Kukes and Lezhe, have the highest incidents of “Unsatisfying setup of HC” with a rate of over

30%. Following close behind are the Gjirokaster and Elbasan districts with almost 30% and approximately 24%, respectively. The majority of the sampled health centers fall in the “Somewhat proper setup of HC” classification.

Table 10

	North region	Middle region	South region	Total
Excellent setup of HC	16.2	24.8	29.8	119
Somewhat proper setup of HC	61.5	59.9	56.7	284
Unsatisfying setup of HC	29.8	56.7	13.5	79

Table 11

	Excellent setup of HC	Somewhat proper setup of HC	Unsatisfying setup of HC	Total
North region				
Diber	13.8	79.3	6.9	29
Kukes	10.0	60.0	30.0	30
Lezhe	13.3	50.0	36.7	30
Shkoder	24.4	58.4	17.1	41
Middle region				
Durres	23.3	76.7	0.0	30
Elbasan	16.2	59.5	24.3	74

	Excellent setup of HC	Somewhat proper setup of HC	Unsatisfying setup of HC	Total
Tirana	45.5	45.5	9.1	33
South region				
Berat	24.3	64.9	10.8	37
Fier	32.2	59.3	8.5	59
Gjirokaster	29.7	40.5	29.7	37
Korce	40.4	51.1	8.5	47
Vlore	17.1	68.6	14.3	35

5.3 Health Center Opening

The opening procedures of health centers monitored are based on the service timetable exposed or declared by the health center personnel. The quality standard document clearly requires that the institution have a system for determining the exact time of visit of the patients. In the standards document the patients may contact the health center by phone and may have the opportunity to take the appropriate service according to regulations out of the office hours. Health staff makes home visits to patients physically impossible or cannot walk.⁷

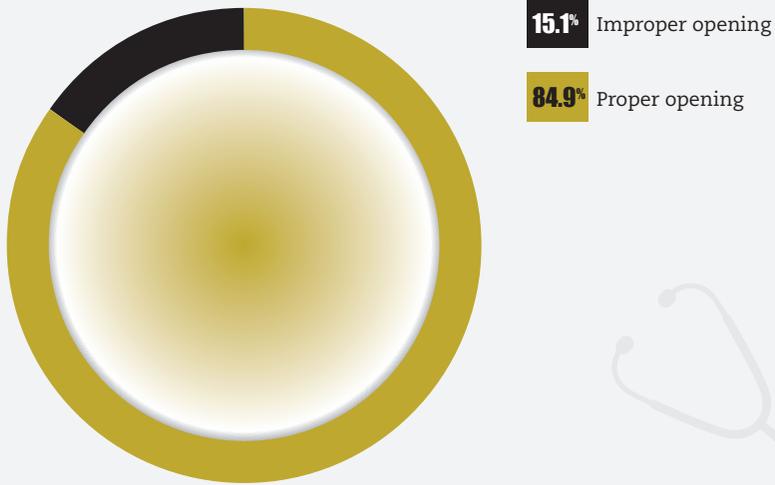
A new variable called HC Opening was created from a combination of survey questions related to the opening procedures of health centers. Answers to these questions are classified as “correct” or “incorrect” and the tabulations of positive answers create the variable. 1 or 2 is considered improper opening and 3 or 4 is proper opening.

1. When was the health center opened?
2. Who was present at the time of the health center opening? The receptionist? A nurse? A doctor? Other personnel?
3. Were patients waiting when the health center opened?
4. Were patients left to wait for an unjustified reason?

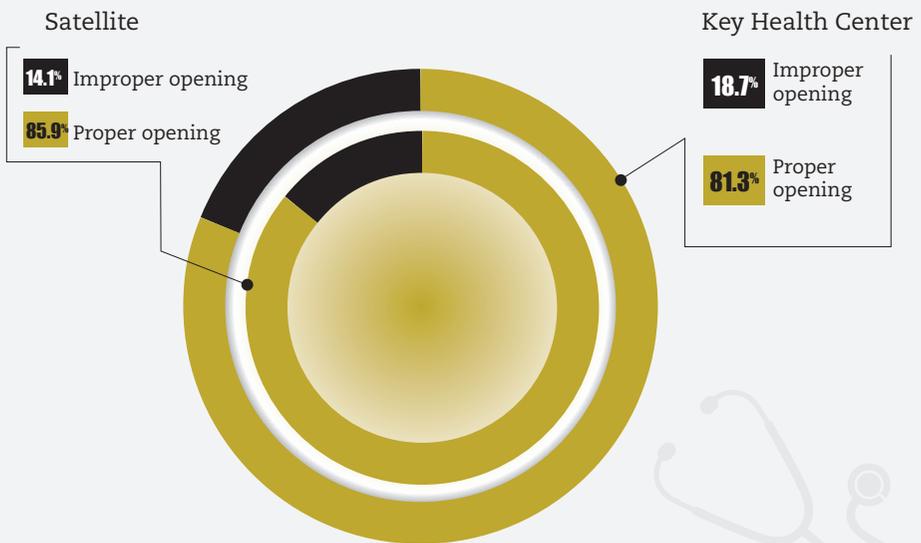
The tabulations based on the entire sample are shown in Graph 5 and the cross tabulations by health center type are shown in Graph 6.

⁷ The Basic Package of Primary Health Care Services, adopted in January 2009; Quality Standards for the Accreditation of Institutions of Primary Health Care, adopted in February 2009.

Graph 5
Health Center Opening



Graph 6
Health Center Opening



Clearly health centers are overall following the proper opening procedures with almost 85% of the centers following appropriate opening rules. The key and satellite health centers show similar results with 81% and about 86% for them respectively.

The individual question with the most incorrect answers is related to the people present at the time of opening. This means that at the opening of the health center, the doctor usually was present in around 62% of the sampled health centers. The remaining questions, though, show high incidents of correct operations. All details can be seen below in Table 12.

Table 12

	Percent / Correct
When was the health center opened? <i>Correct answer: On time</i>	89.4
Who was present at the time of the health center opening?	
The receptionist? <i>Correct answer: Yes</i>	85.9
A nurse? <i>Correct answer: Yes</i>	95.1
A doctor? <i>Correct answer: Yes</i>	62.4
Other personnel? <i>Correct answer: No</i>	93.7
Were patients waiting when the health center opened? <i>Correct answer: No</i>	90.3
Were patients left to wait for an unjustified reason? <i>Correct answer: No</i>	98.7

The graphs below present the cross tabulations by region, in Table 13, and by district, in Table 14.

The percentages by region show that the lowest incidents of proper openings and highest incidents of improper openings occur in the central region of Albania. A closer look by district shows that other than Vlore in the Southern region, the lowest incidents of proper openings occur in all three districts of the central region in Albania.

Table 13

	North region	Middle region	South region	Total
Proper opening	89.2	79.0	84.2	406
Improper opening	10.8	21.0	15.8	77

Table 14

	Proper opening	Improper opening	Total
North region			
Diber	100.0	0.0	29
Kukes	80.0	20.0	30
Lezhe	90.0	10.0	30
Shkoder	87.8	12.2	41
Middle region			
Durres	86.7	13.3	30
Elbasan	77.3	22.7	75
Tirana	75.8	24.2	33
South region			
Berat	91.9	8.1	37
Fier	89.8	10.2	59
Gjirokaster	83.8	16.2	37
Korce	80.9	19.1	47
Vlore	71.4	28.6	35

5.4 Health Center Accessibility for People with Disabilities

It is necessary that ramps, elevators, and other facilities are provided for people with disabilities. This is required in the standards document but it is not clearly defined.⁸

⁸ The Basic Package of Primary Health Care Services, adopted in January 2009; Quality Standards for the Accreditation of Institutions of Primary Health Care, adopted in February 2009.

HC Access was a new variable created from a combination of survey questions related to the accessibility of the health center to people with disabilities. Answers to these questions either “yes” or “no” and the tabulations of “yes” answers create the variable. A value of 3 is considered to be accessible to people with disabilities and any other answer is considered not a user-friendly health center.

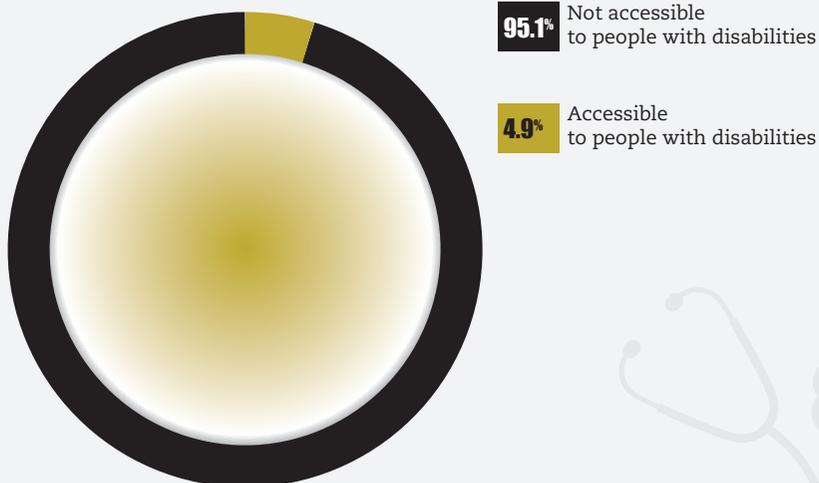
1. Is the health center adapted for people with disabilities (ramp or elevators)?
2. Are rooms adapted for people with disabilities?
3. Are restrooms adapted for people with disabilities?

The tabulations based on the entire sample are shown in Graph 7 and the cross tabulations by health center type are shown in Graph 8.

It is quite blatant that the health centers in Albania are not equipped to serve the disabled population with 95% of the sampled health centers showing lack of adaptations for disable patients. This percentage is not concentrated in key or satellite health centers as their percentages are similar to the nationwide tabulations.

Graph 7

Health Center Accessibility for People with Disabilities



Graph 8

Health Center Accessibility for People with Disabilities

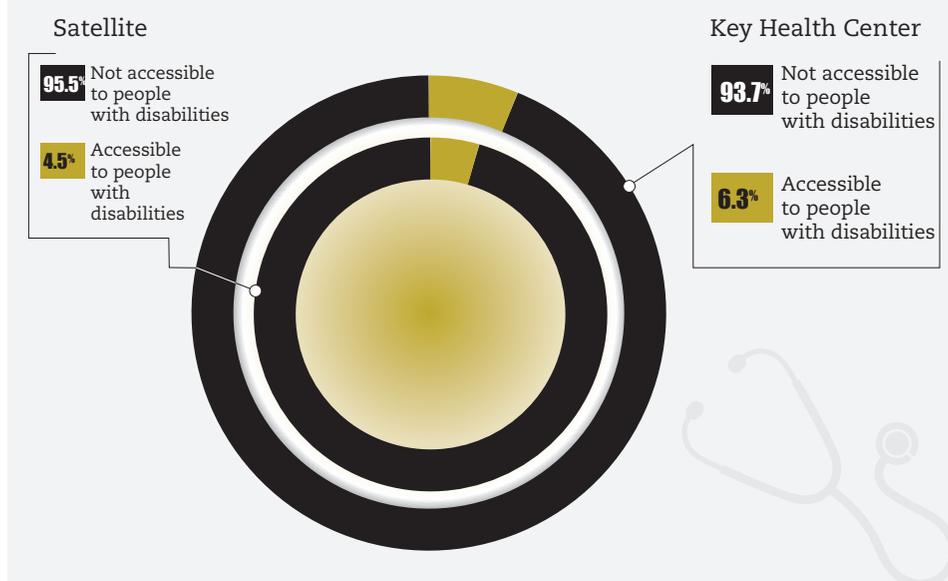


Table 15

	Percent / Yes
Is the health center adapted for people with disabilities (ramp or elevators)?	12.5
Are rooms adapted for people with disabilities?	13.5
Are restrooms adapted for people with disabilities?	9.8

Table 15 above shows the percentages for each component of the variable HC Access. All of the components of this scale have low frequencies of almost 15% and lower meaning that, in general, the health centers are not accessible to people with disabilities. The restrooms are most commonly not disabled accessible for 9.8% of sampled health centers.

Table 16 and 17 below show the variable data by region and then district. First, it is seen that the sampled health centers in the North region are more accessible to disabled patients with 10.2% while the Centre region and South region are below 5% for this same measure. For the districts

sampled, the highest percentages of accessible health centers are not surprisingly found in the North region with Diber having the highest value of 17.9%, Lezhe at 13.8%, and Shkoder at 10.0%. Districts that were not accessible at all with zero values are Kukes, Durres, and Vlore.

Table 16

	North region	Middle region	South region	Total
Disabled User Friendly	10.2	2.2	4.3	25
Not Disabled User Friendly	89.8	97.8	95.8	451

Table 17

	Disabled User Friendly	Not Disabled User Friendly	Total
North region			
Diber	17.9	82.1	28
Kukes	0.0	100.0	31
Lezhe	13.8	86.2	29
Shkoder	10.0	90.0	40
Middle region			
Durres	0.0	100.0	30
Elbasan	2.7	97.3	30
Tirana	3.0	97.0	33
South region			
Berat	5.4	94.6	37
Fier	6.9	93.1	58
Gjirokaster	5.6	94.4	36
Korce	2.1	97.9	47
Vlore	0.0	100.0	34

5.5 Health Center Services

The questions for the health center services are based on the Package of the Primary Health Care Service in Albania approved by the Ministry of Health.

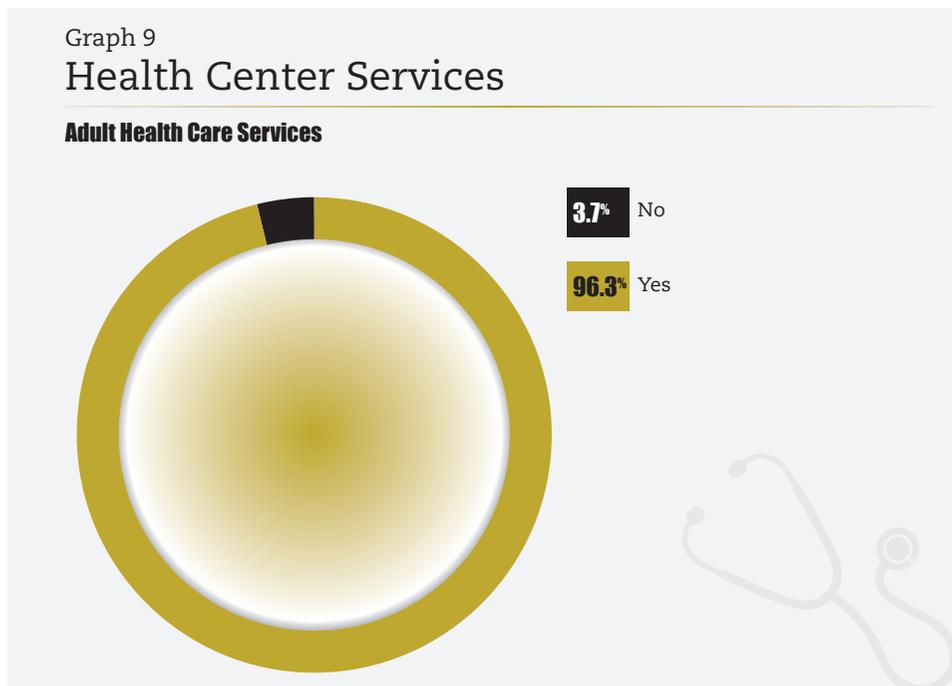
The frequencies of the following survey questions help the team to determine if the health centers are providing the required services. Each of these questions has “yes” or “no” answers with the base question of “Please describe the services provided by this center:”

The tabulations based on the entire sample and the cross tabulation by health center type are shown in Graphs 9. The survey questions are shown above the tabulations.

Overall, all services are provided at the nationwide health center level in high percentages of 95% and above. Similar trends are seen when dividing the answers by key and satellite health centers.

The cross tabulations in Table 18 below show the regional data for services offered. Table 18.1 show the data by district.

The regional data represents the nationwide data similarly for North region, Middle region, and South region. The district level cross tabulations give more details of these regions. For health centers that offer Adult Health Services, all districts have high values with Vlore showing a value of 100% of all sampled health centers. The lowest value was for Kukes at almost 88%. Looking to Pediatric Health Services, all values are over 90% with the highest value of 100% for the sample health centers in Diber.



Graph 9 Health Center Services

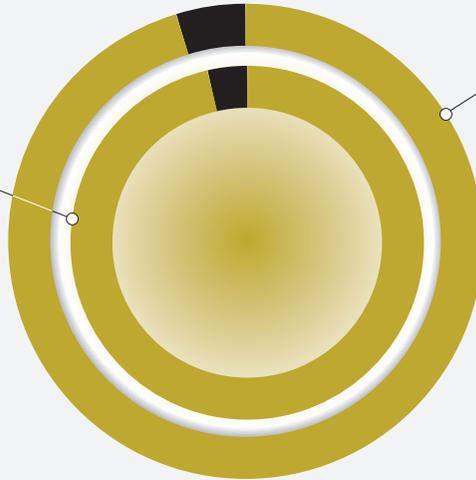
Adult Health Care Services

Satellite

3.5% No
96.5% Yes

Key Health Center

4.7% No
95.3% Yes

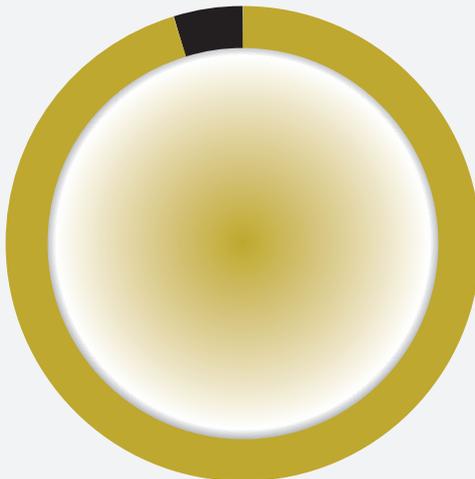


Graph 9 Health Center Services

Pediatric Health Services

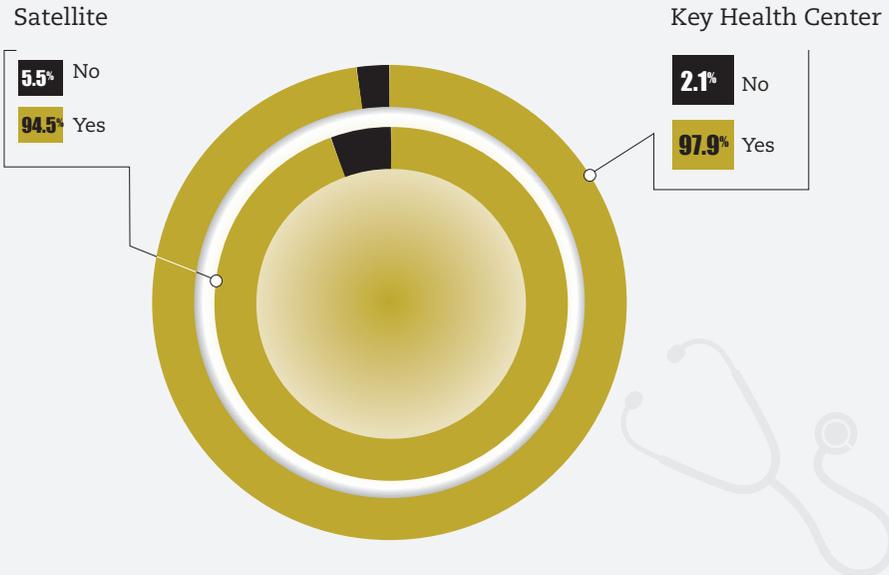
4.7% No

95.3% Yes



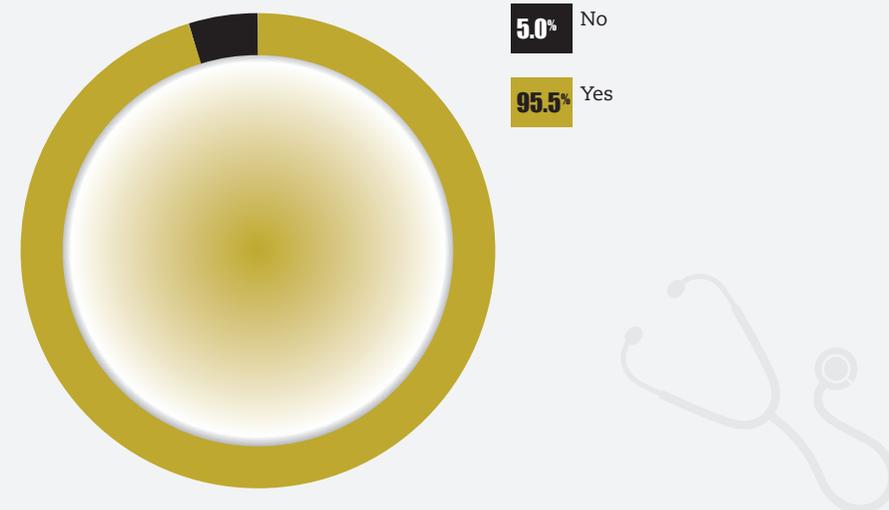
Graph 9 Health Center Services

Pediatric Health Services



Graph 9 Health Center Services

Emergency Services



Graph 9

Health Center Services

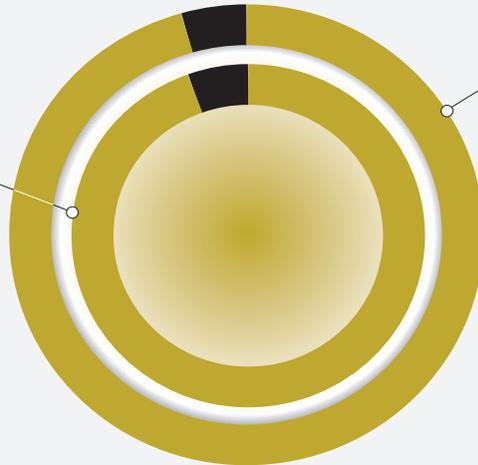
Emergency Services

Satellite

5.2% No
94.8% Yes

Key Health Center

4.2% No
95.8% Yes



For Emergency Services, Diber, Shkoder, and Berat all have values of 100% meaning that all sampled health centers offer emergency services. Remaining districts have high values but the lowest reported percent of 87.1% is in the Tirana district.

Table 18

1. Adult Health Services

	North region	Middle region	South region	Total
Po	93.9	95.6	97.7	461
Jo	6.1	4.4	2.4	19

2. Pediatric Health Services

Po	95.5	94.9	96.8	467
Jo	4.5	5.1	3.2	20

3. Emergency Services

Po	97.7	92.6	95.4	458
Jo	2.3	7.4	4.7	23

Table 18.1

	Adult Health Services		Pediatric Health Services		Emergency Services	
	Yes	Total	Yes	Total	Yes	Total
North region						
Diber	93.1	29	100.0	29	100.0	28
Kukes	87.9	33	96.9	33	93.8	32
Lezhe	96.7	30	93.3	30	96.7	30
Shkoder	97.5	40	92.7	41	100.0	41
Middle region						
Durres	96.6	29	93.3	30	96.7	30
Elbasan	94.6	74	94.7	75	93.2	74
Tirana	96.9	32	96.9	32	87.1	31
South region						
Berat	97.3	37	97.2	36	100.0	36
Fier	98.3	59	98.3	58	96.6	59
Gjirokaster	97.2	36	94.7	38	89.2	37
Korce	95.7	47	95.8	48	97.9	48
Vlore	100.0	34	97.1	35	91.4	35

5.6 Relationship with Institute of Insurance and Health Care (IIHC)

The relationship between the key health centers and the [IHCs](#) regulated by a General Regulation for Contracting the Health Care Services. This regulation is only for key health centers in Albania. HC IIHC is a new variable created from a combination of survey questions related to the administration of the health center and how it is related to the IIHC. Answers to these questions are classified as either “proper” or “improper” and the summation of all “proper” answers creates the scale. A value of 4 is considered to “proper” and any other answer is considered “improper.” The questions below are used to make the scale:

1. Do you have an agreement with IIHC?
2. Does IIHC supervise your health center?
3. Do you regularly report to the IIHC?
4. Have you ever been audited?

The tabulations based on the entire sample are shown in Table 19 and the cross tabulations by health center type are shown in Graph 10.

Table 19

	Percent
Proper relationship	67.5
Improper relationship	32.5

Based on the data collected, 67.5% of the health centers have a proper relationship with the IIHC. ~~Looking to the key health centers versus the satellite centers, key health centers have higher frequencies of proper relationships at 83.3% compared to the satellite health centers with 62.7%.~~

Table 20

	Percent / Proper
Do you have an agreement with IIHC?	96.3
<i>Correct Answer: Yes</i>	
Does IIHC supervise your health center?	93.5
<i>Correct Answer: Yes</i>	
Do you regularly report to the IIHC?	94.1
<i>Correct Answer: Yes</i>	
Have you ever been audited?	71.6
<i>Correct Answer: Yes</i>	

Graph 10

Relationship with Institute of Insurance and Health Care (IIHC)

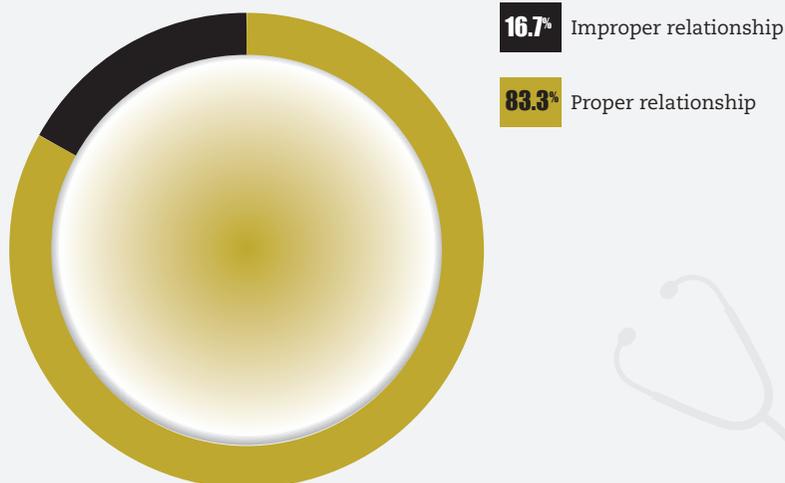


Table 20 above shows the survey questions that make up the variable HC IHC. The lowest value found by survey question is related to whether the health center has been audited with a value of 71.6%. All other proper values for the remaining questions have high frequencies all over 90%.

For the regional data in Table 21, the central area of Albania shows the lowest percentage of a proper relationship with the IHC. The highest percentage of a proper relationship is seen in the North region. Within the regions shown in Table 22, the districts with the highest percentage of proper relationships are seen in Durres with 88.0%, Tirana at 84.4%, and Vlore with 84.0%. The lowest values are found in Gjirokaster and Elbasan with 50.0% and 55.4% respectively.

Table 21

	North region	Middle region	South region	Total
Proper relationship	75.4	69.7	70.2	301
Improper relationship	24.6	30.3	29.8	120

Table 22

	Proper Relationship	Improper Relationship	Total
North region			
Diber	76.9	23.1	26
Kukes	71.4	28.6	28
Lezhe	77.8	22.2	27
Shkoder	75.7	24.3	37
Middle region			
Durres	88.0	12.0	25
Elbasan	55.4	44.6	65
Tirana	84.4	15.6	32
South region			
Berat	67.7	32.3	34
Fier	74.1	25.9	54
Gjirokaster	50.0	50.0	26
Korce	71.4	28.6	42
Vlore	84.0	16.0	25

5.7 Investments in Health Centers

Investments in the health centers in Albania are covered by the Fund, Ministry of Health, or donors. The health centers are eligible to apply for loans based the protocols.

To measure the investments made in the health centers, a scale was created called HC Investment created from a combination of questions. Answers of the questions listed below all have “yes” or “no” answers. The total number of “yes” answers creates the scale where 5 or 4 indicate “substantial investment,” 3 or 2 as “some investments,” and 1 or 0 as “minor or no investment.”

1. Have you ever received a bank loan?
2. Have you raised funds with foreign donors or domestic business?
3. Have you received bonuses at the end of the last year (2013)?
4. Has the Ministry of Health ever invested in your center?
5. Have you ever involved your staff in professional trainings?



The tabulations based on the entire sample are shown in Table 23 and the ~~cross~~ tabulations ~~by~~ health center type are shown in Graph 11

Table 23

	Percent
Substantial investments	16.4
Some investments	29.5
Minor or no investments	26.5
Missing Information	27.6

In general, investments are not a substantial aspect of the health centers with low percentages for the nationwide tabulations. When dividing this among the key and satellite health centers, substantial investments are higher in the key health center at 34.1% compared to 19.4% for satellite. 

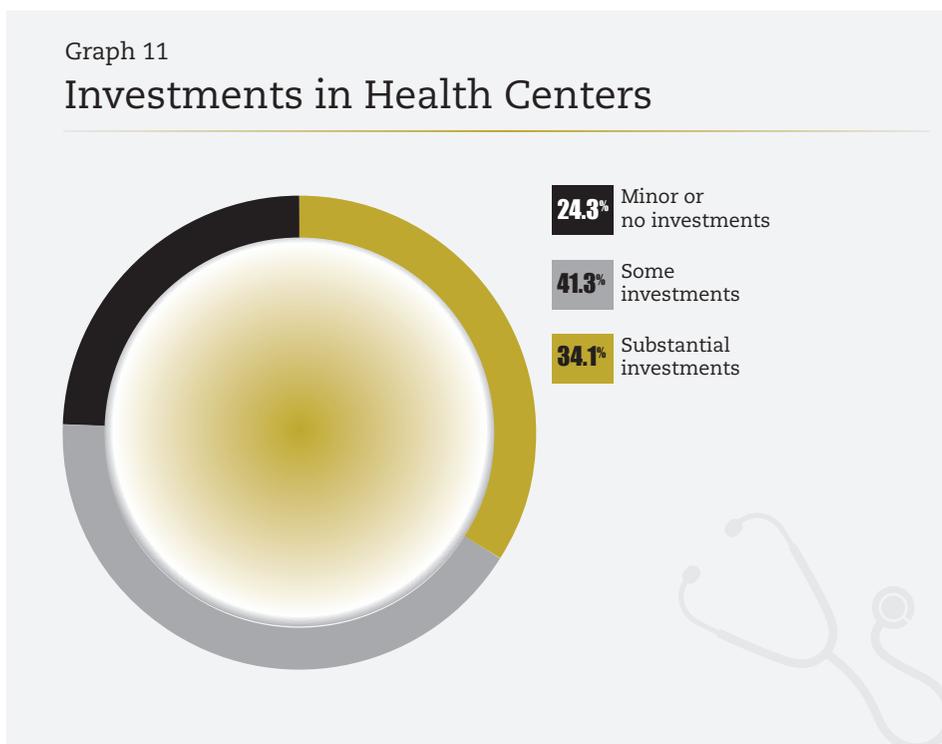
Looking to the components of the variable HC Investment in Table 24 below shows that the investments are predominantly made in professional trainings with over 85% of sampled health centers participating. The lowest values for investment activities are seen in receiving a bank loan and with fundraising partnerships.

Table 24

	Percent / Yes
Have you ever received a bank loan?	4.3
Have you raised funds with foreign donors or domestic business?	5.4
Have you received bonuses at the end of the last year (2013)?	57.5
Has the Ministry of Health ever invested in your center?	29.7
Have you ever involved your staff in professional trainings?	85.3

Graph 11

Investments in Health Centers



The regional data in Table 25 also reflects that investment is usually in the “Some investments” category. The North region is the highest for this category at 48.7%. For the district data shown in Table 26, the highest value for “Substantial investments” is seen in Tirana at 40.0% with Korce and Berat with the second and third highest values. A high value for Tirana

could reflect the fact that the capital city is located in that district and the availability of the items above are easier for those sampled health centers to access. The district with the highest “Some investments” value is Kukes with a value of 53.6%. Finally, for the last category of “Minor or no investments” the district that has the highest values is Elbasan with almost 46%.

Table 25

	North region	Middle region	South region	Total
Substantial investments	23.5	24.4	27.7	106
Some investments	48.7	36.9	38.4	170
Minor or no investments	27.7	38.7	33.9	139

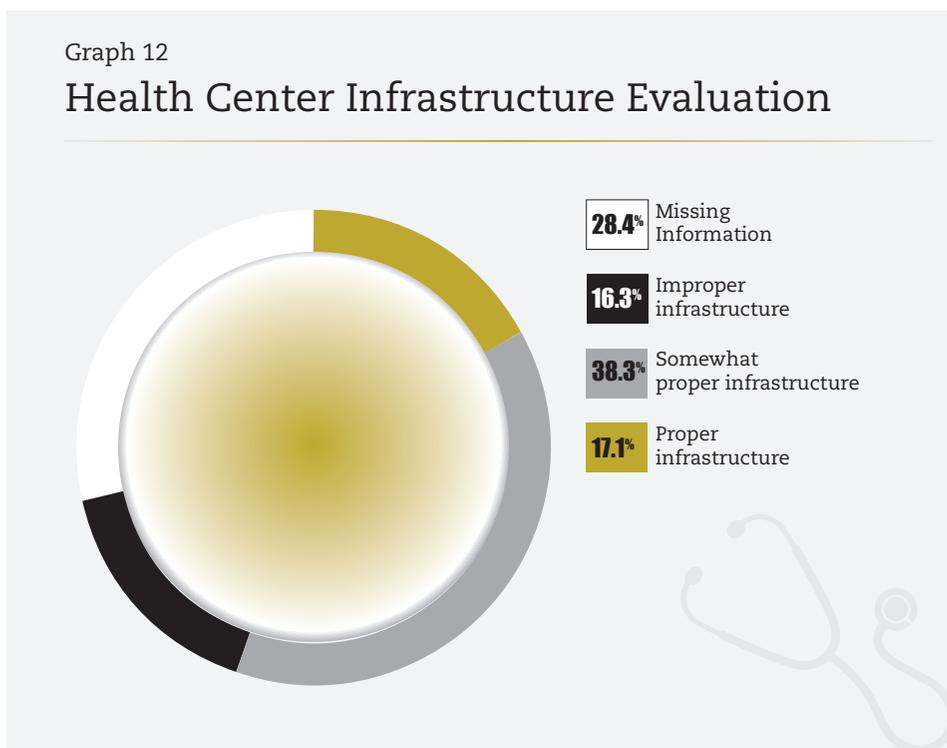
Table 26

	Substantial investments	Some investments	Minor or no investments	Total
North region				
Diber	25.0	46.4	28.6	28
Kukes	21.4	53.6	25.0	28
Lezhe	25.9	48.2	25.9	27
Shkoder	22.2	47.2	30.6	36
Middle region				
Durres	28.6	39.3	32.1	28
Elbasan	14.8	39.3	45.9	61
Tirana	40.0	41.7	37.5	24
South region				
Berat	33.3	30.3	36.4	33
Fier	23.1	38.5	38.4	52
Gjirokaster	24.0	36.0	40.0	25
Korce	34.9	44.2	20.9	43
Vlore	20.8	41.7	37.5	24

5.8 Health Center Infrastructure Evaluation

A new variable called HC Infrastructure was created from a combination of survey questions health center infrastructure. This whole section of the questionnaire is comprised of 39 questions with the base of “Are the following provisions present?” Answers to these questions are classified as “yes” or “no” and the tabulations of “yes” create the scale. Greater than 26 indicates proper infrastructure, from 13 to 26 is considered somewhat proper infrastructure, and less than 13 is considered improper infrastructure. Details of all of these questions can be seen in the original questionnaire but examples of questions include functional electrical and water systems, the presence of examination rooms for adults and children, clean beds and sheets, etc.

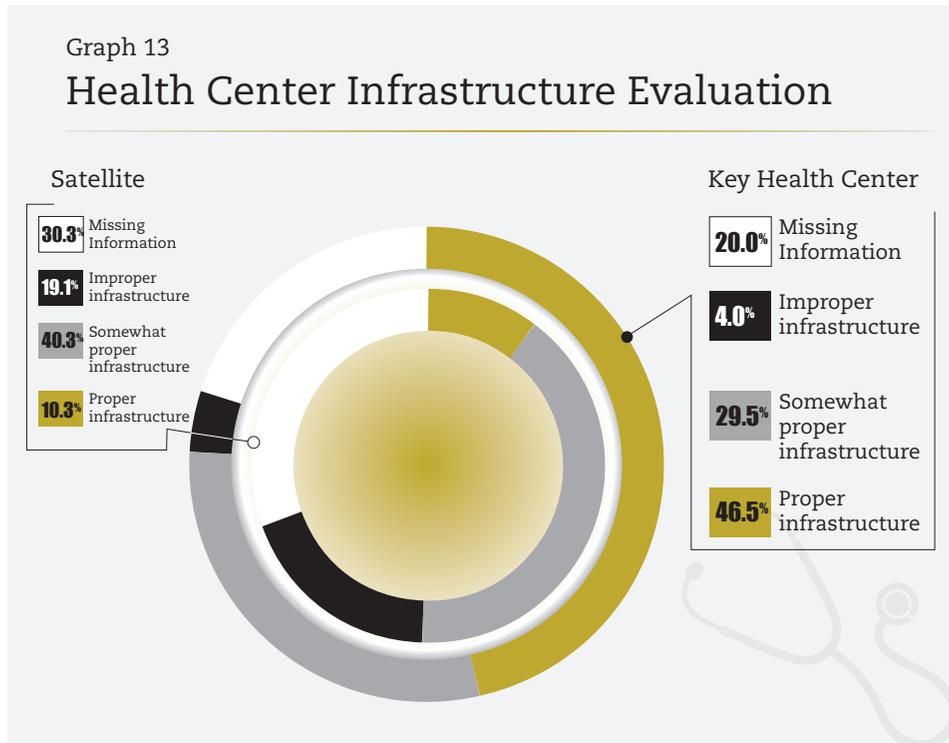
The tabulations based on the entire sample are shown in Graph 12 and the cross tabulation by health center type are shown in Graph 13.



Based on the observations of CFFESD field monitors the infrastructure of health centers is classified with 17.0% as proper, 38.3% of cases somewhat proper, and 16% with improper infrastructure. Distributed by key and satellite health centers, 46.5% of key health centers have proper

infrastructure, 29.5% somewhat proper infrastructure, and 4.0% with an improper classification. These results indicate that the key health centers are, in general, more prepared with proper infrastructure than the satellite health centers have higher frequencies of somewhat proper infrastructure.

Questions with the highest “no” responses are if the health center has an alternate electrical system during power outages, if there is functioning Internet service, and if there are separated bathrooms for males and females. The questions with the highest frequencies of “yes” include if the health center has a set of table and chairs, if medicines are within their expiration dates, and if the center provides home care for patients that are unable to make it to the center. The complete data on all of the questions are listed below in Table 27.



9 Missing information indicates that the health center did not complete this section. The interpretation of the tabulations should be emphasized to be among the answering sampled health centers.

Table 27

	Percentage Yes
Is the electrical system functioning?	75.4
Is there a backup electrical system for when there are power outages?	6.4
Does the plumbing work in the center?	65.1
Is there running water?	58.2
Is there a functioning water deposit for when the water system is not working?	42.2
Are the bathrooms to regulation?	65.6
Are the bathrooms separated for males and females?	15.5
Is there a room for garbage?	24.9
Are people protected from sun and rain when they wait?	76.6
Does the air conditioner and heater work?	27.8
Is there a separate room for pregnant women and small children consultations?	55.2
Is there counselor for children?	55.8
Is there a diagnosis room for adults?	65.5
Is there a diagnosis room for children?	50.9
Is there a telephone system inside and outside the building?	22.5
Does the health center have a computer in a secure place?	28.2
Is there Internet?	18.7
Is there a printer?	20.4
Are there any signs in a 150 meter radius indicating that there is a health center?	20.8
Are the sheets clean on the patient beds?	84.5
Is there a table and chairs?	94.3
Are there privacy curtains or separators?	35.3
Does the bathroom have hot and cold water with soap?	33.1
Do the waiting rooms have enough chairs?	45.8

	Percentage Yes
Does the doctor's room have a sink with water and soap?	61.1
Does the health center have a complete equipment register?	80.7
Does the health center have a complete medicine register?	90.9
Are medicines within their expiration dates?	94.1
Is there a refrigerator at the appropriate temperature for medicines?	46.0
Does the health center have soap, detergent, towels, toilet paper, and paper towels?	59.2
Is there a system that regulates visiting hours?	55.2
Is there a phone number patients can use to set an appointment?	30.3
Are there home services for patients who cannot physically come to the health center?	93.2

Cross tabulations are performed below by region in Table 28 and by district in Table 29.

Regardless of the region, the majority of sampled health centers that answered the questions fall into the “Somewhat proper infrastructure” category. The Middle region has the highest percentage value for “Proper infrastructure” and could be linked to the resources available to the centers closer to the capital. The overall percentages for “Proper infrastructure” are higher than the “Improper infrastructure” percentage and indicates that the health centers have more positive outcomes for this measure than not.

Districts with the highest percentage for “Proper infrastructure” are mainly found in the central districts of Tirana and Durres. The second highest value for this measure, though, is found in the North region district of Diber with 32.3%. Higher percentages for the “Somewhat proper infrastructure” category with the majority of these high values found in the Southern region. The highest values are found in Fier (44.4%), Berat (42.1%), and Shkoder (41.3%). The sampled health centers with the strongest value for “Improper infrastructure” are found in Kukes at 33.3%. But, interestingly, the second highest value of 25.0% can be found in the central region in Elbasan.

Table 28

	North region	Middle region	South region	Total
Proper infrastructure	20.9	29.0	21.8	129
Somewhat proper infrastructure	33.3	35.9	38.5	200
Improper infrastructure	17.7	15.2	10.3	75
Missing Information	28.1	20.0	29.4	146

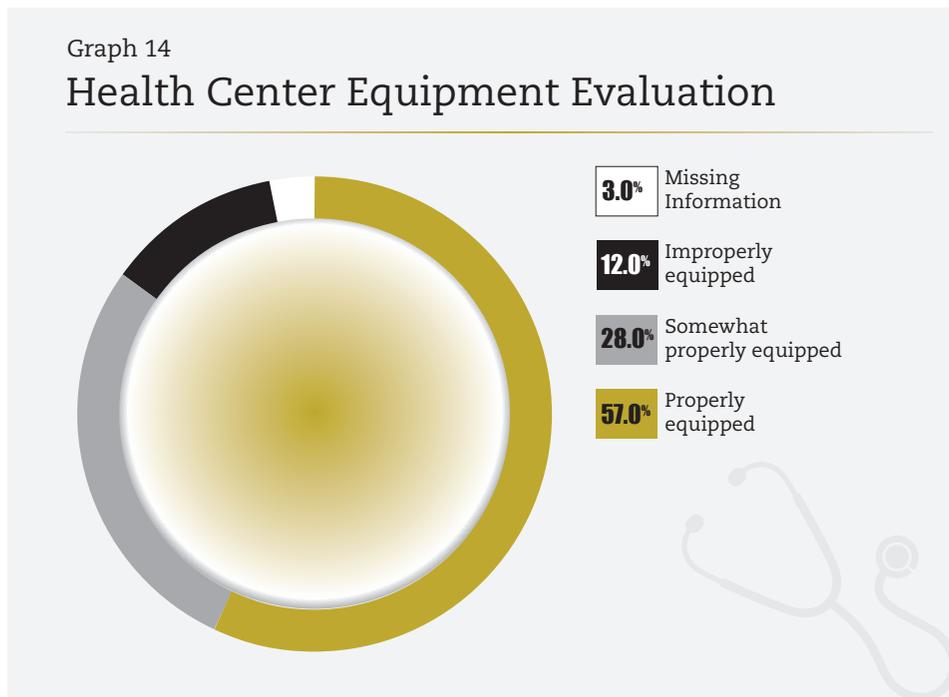
Table 29

	Proper infrastructure	Somewhat proper infrastructure	Improper infrastructure	Missing Information	Total
North region					
Diber	32.3	29.0	16.1	22.6	31
Kukes	15.4	23.1	33.3	28.2	39
Lezhe	10.8	37.8	16.2	35.1	37
Shkoder	26.1	41.3	6.5	26.1	46
Middle region					
Durres	31.3	31.3	3.1	34.4	32
Elbasan	20.0	36.3	25.0	18.8	80
Tirana	48.5	39.4	3.0	9.1	33
South region					
Berat	26.3	42.1	13.2	18.4	38
Fier	20.6	44.4	14.3	20.6	63
Gjirokaster	14.6	25.0	8.3	52.1	48
Korce	29.1	40.0	9.1	21.8	55
Vlore	23.5	36.4	13.6	26.6	48

5.9 Health Center Equipment Evaluation

The new variable was created to look at the evaluation of the health centers called HC Equipment. This scale was created from combining all the questions for the fifth section called Primary Health Center Equipment. In total, 45 questions were asked about the equipment that health centers have with “yes” or “no” as responses. The summation of all “yes” answers creates the scale where greater than 30 meaning “properly equipped,” from 15 to 30 “yes” answers as “somewhat properly equipped,” and less than 15 as “improperly equipped.”

The tabulations based on the key health centers are shown in Graph 14.



Based on the nationwide tabulations, more than half of the health centers are properly equipped at 57% of the sample. More than two-thirds of the health centers are either properly or somewhat properly equipped.

The equipment monitored to create this variable are listed below in Table 30 with the percentage of “Yes” answers shown indicating that it was found at the sampled health center. Equipment that is presents the least in the sampled health centers are ultrasound machines at 3.2%, photometers at 3.8%, and centrifuges at 4.6%. For equipment that appears most often, the highest percentages are found for adult sphygmomanometers(94.4%),

thermometers (93.5%), and scissors (89.9%). Concerning levels are seen for items related to women's health such as materials for PAP smears and gynecological exam tables.

Table 30

	Percent / Yes
Micro surgery kit	47.1
Tools for giving medicine	22.2
Masks	50.1
Fixed and movable light	28.8
Nose speculum	32.1
Otoscope	48.6
Ophthalmoscopes	25.8
Glucose meter	48.7
Pen light	56.6
Reflex hammer	54.9
Adult scale	63.0
Child scale	82.2
Growth graphs	61.5
Adult sphygmomanometers	94.4
Child sphygmomanometers	29.4
Child stethoscope	61.6
Adult stethoscope	83.1
Obstetric stethoscope	55.3
Height measuring tape	82.4
Tracks for fractures	11.4
Sterilization equipment	43.6
Refrigerator	51.2
Mobile refrigerator for vaccines	69.1
Thermometer	93.5
Tongue suppressors	78.7
Tuning fork	30.1
Eye test poster	50.9

	Percent / Yes
Ear syringe	22.3
Scissors	89.9
Percussion and neurological hammer	46.0
Mechanical timer	48.2
Oxygen tank	14.2
Inhaler mask	25.4
Gynecological instruments	25.7
Pelvimeter	55.1
Gynecological exam table	18.4
Small speculum	13.2
Medium speculum	14.9
Large speculum	13.4
Materials for PAP smear	11.6
EKG	4.9
Autoclave	21.2
Photometer	3.8
Centrifuge	4.6
Ultrasound machine	3.2

Returning to the equipment scale, Table 31 shows the key health center data separated by region with Table 32 showing the district results.

The central region has the highest incidents of “Properly equipped” sampled key health centers, which is not surprising due to the easy access of those health centers to regular equipment suppliers in the capital city. This is reflected in the district data seen for the Center with the highest percentages of proper equipment seen in Tirana and Durres. The majority of health centers are properly and somewhat properly equipped and that is reflected in the regional and district data. However, there are high values of “Improperly equipped” key health centers that can be seen in the North region and South region with the highest value seen in Gjirokaster (33.3%), followed by Shkoder (27.8%), and then Kukes (23.1%).

Table 31

	North region	Middle region	South region	Total
Properly equipped	38.6	72.1	58.5	114
Somewhat properly equipped	35.1	22.9	26.8	56
Improperly equipped	19.3	4.9	12.2	24
Missing information	7.0	0.0	2.4	6

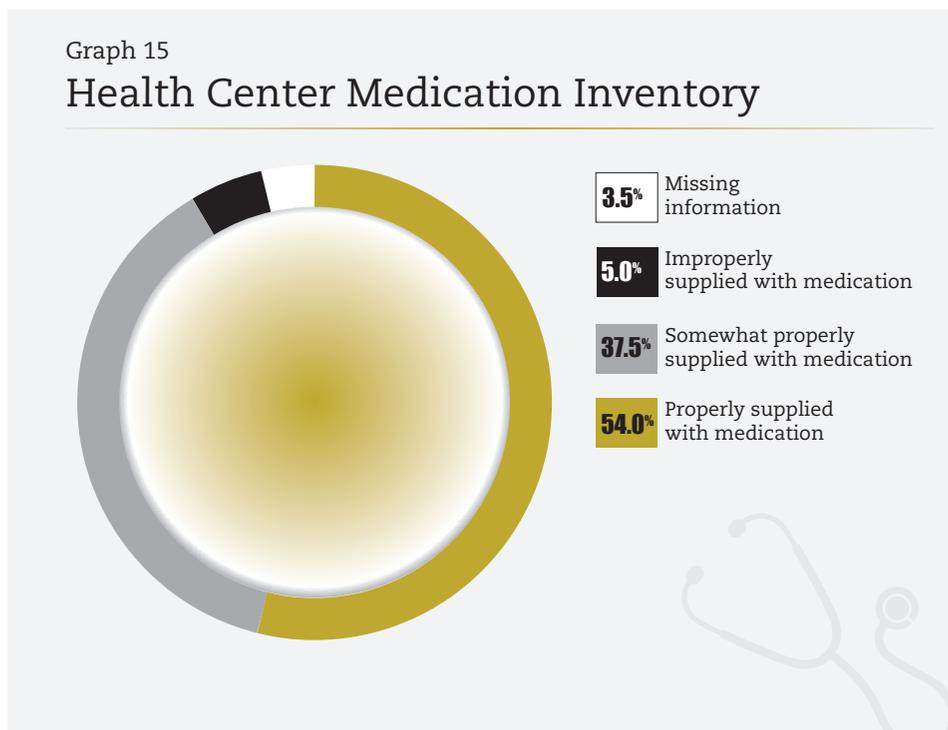
Table 32

	Properly equipped	Some-what properly equipped	Improperly equipped	Missing Information	Total
North region					
Diber	37.5	43.8	18.8	0.0	16
Kukes	30.8	38.5	23.1	7.7	13
Lezhe	50.0	30.0	0.0	20.0	10
Shkoder	38.9	27.8	27.8	5.6	18
Middle region					
Durres	76.9	15.4	7.7	0.0	13
Elbasan	64.0	28.0	8.0	0.0	25
Tirana	78.3	21.7	0.0	0.0	23
South region					
Berat	54.6	27.3	18.2	0.00	11
Fier	68.2	22.7	9.1	0.00	22
Gjirokaster	33.3	26.7	33.3	6.7	15
Korce	68.4	26.3	0.0	5.3	19
Vlore	60.0	33.3	6.7	0.0	15

5.10 Health Center Medication Inventory

Similar to the medical equipment scale, a variable called HC Medicine is created from the inventory list found in the medication inventory of section 6 of the questionnaire. A total of 61 items are questioned with “yes” and “no” answers. The total “yes” answers create the scales with greater than 40 classified as “properly supplied,” from 20 to 40 as “somewhat supplied,” and less than 20 as “improperly supplied.”

The tabulations based on the key health center sample are shown in Graph 15.



More than half of the health centers are properly supplied with medication at 54.0%. In general, the medication supplies are either properly or somewhat properly supplied with medications with more than 75.0% of the sample showing this.

In the Table 33 below, all of the medication inventory items are shown. The least common medications found are the black spider serum and dihydroergotamine used to treat headaches. The most common medication observed in the sampled health centers is diazepam used for anxiety and seizures. Following close behind is furosemide used for swelling and high blood pressure.

Table 33

	Percent / Yes
Water for injections	90.1
Atropine sulfate 0.1% (1mg/1ml)	81.6
Dextrose 5% (500ml)	66.6
Dextrose 40% (10ml)	54.1
Manitol 20% (250ml)	54.6
Diazepam (10mg/2ml)	93.4
Epinephrine 0.1% (1ml)	52.1
Furosemide (20mg/2ml)	92.5
Lidocaine 15% (2ml)	67.8
Natriumchloride 0.9% (10ml)	67.8
Natriumchloride 0.9% (500ml)	76.0
Nitroglycerin (0.5mg)	68.4
Vitamin K 1% (1ml)	72.7
Dexametazon (5mg)	72.7
Antitetanic Serum (1500 units)	69.9
Antivipera Serum (10ml)	48.2
Black spider serum	13.2
Tresol (27.9gr)	74.2
Bipenicilin (6000000UI)	28.2
Haloperidol (5mg/ml)	40.6
Metoklopramid (10mg/2ml)	55.5
Prochlorperazine (12.5mg/ml)	33.7
Aspirin (0.5gr)	75.9
Morphine sulfate (15mg or 30mg)	22.7
Tramadol (100mg/2ml)	69.8
Diklofenak (50mg)	69.3
Salbutamol	31.8
Hydrocortisone (100mg/2ml)	45.8
Papaverine 4% (1ml)	86.2
Oxytocin (5ul)	30.2
Vepramil (5mg/2ml)	25.1
Dihydroergotamine(1mg/ml)	13.8

	Percent / Yes
Contraceptive DIU	32.4
Oral contraceptive	51.9
Injectable contraceptive	46.9
Different vaccines	68.5
Plastic perfusion system	70.8
Spiritsaethylicus 70% (alcohol)	76.3
Plastic syringe (3ml)	91.7
Plastic syringe (5ml)	93.7
Plastic syringe (10ml)	88.5
Tincturajodi 2% (500ml)	79.4
Materials for stitches	59.2
Nebulizer	23.8
Surgical gloves	81.6
Gentian violet solution 1%	33.5
Cholecalciferol	22.3
Amoxicillin	34.3
Chlorfeniramin	21.5
Silver sufadiazine 1% (15g)	31.0
Glycerin suppositories	37.2
Acetaminophen suppository (100mg)	41.2
Sulfadiazine (local cream)	33.3
Folic acid (5mg)	38.6
Silver nitrate pen	31.8
Oxygen	19.6
Bender (5x5cm)	81.6
Gauze (1m)	73.3
Hydrogen peroxide 3%	55.5
Hydrophilic pamuk (100g)	91.1
Magnesium suflate (10ml)	68.7

The regional data in Table 34 continues to show that the central region is more properly supplied than the North region and South region. Improper medication supplies have low percentages for all regions but the central region leads with the highest percentage. Breaking the same data into districts in Table 35, the properly supplied key health centers districts are

usually above 40%. Exceptions to this can be seen in Vlore with 20.0% and in Lezhe with 30.0%. These low values are coupled with higher values for the somewhat properly supplied classification. The district with the highest percentage of “Improperly supplied with medication” is found in a central district of Elbasan with 16.0%. Following Elbasan is Kukes and then Gjirokaster. These results are similar to the equipment results.

Table 34

	North region	Middle region	South region	Total
Properly supplied with medication	47.4	60.7	53.7	108
Somewhat properly supplied with medication	42.1	29.5	40.2	75
Improperly supplied with medication	3.5	8.2	3.7	10
Missing information	7.0	1.6	2.4	7

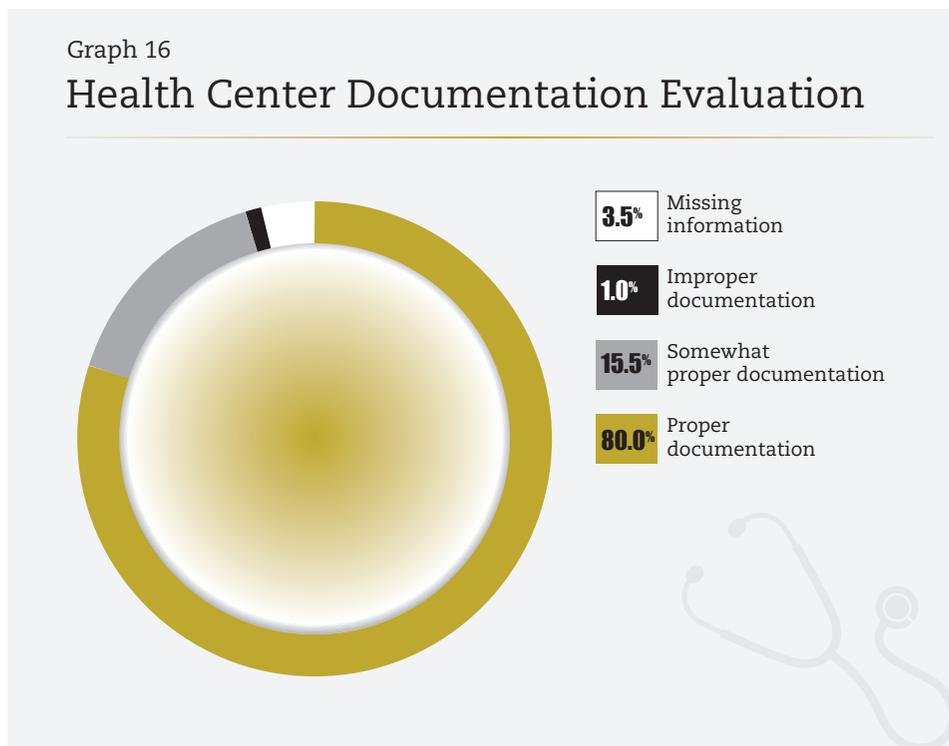
Table 35

	Properly supplied with medication	Some-what properly supplied with medication	Improperly supplied with medication	Missing Information	Total
North region					
Diber	56.3	43.8	0.0	0.0	16
Kukes	46.2	30.8	15.4	7.7	13
Lezhe	30.0	50.0	0.0	20.0	10
Shkoder	50.0	44.4	0.0	5.6	18
Middle region					
Durres	61.5	38.5	0.0	0.0	13
Elbasan	64.0	16.0	16.0	4.0	25
Tirana	56.5	39.1	4.4	0.0	23
South region					
Berat	54.6	45.5	0.0	0.0	11
Fier	63.6	31.8	4.6	0.0	22
Gjirokaster	40.0	40.0	13.3	6.7	15
Korce	78.9	15.8	0.0	5.3	19
Vlore	20.0	80.0	0.0	0.0	15

5.11 Health Center Documentation Evaluation

In the same way as the previous two scales, Section 7 of the questionnaire related to health center documentation is used to create a scale of HC Documentation. A summation of “yes” answers for all 47 questions created the scales. For values greater than 30 it is considered “proper documentation,” from 15 to 30 considered “somewhat proper documentation,” and less than 15 as “improper documentation.”

The tabulations based on the entire sample are shown in Graph 16.



In general, the health centers nationwide keep proper documentation with 80.0% of the health centers having proper documentation and 15.5% of the centers holding somewhat proper documentation.

Table 36 below breaks down the HC Documentation variable by each component related to the key health centers sampled. While many of these values are relatively high, reflecting the nationwide data of the variable, there are some documents that are not commonly found in the health centers sampled. The lowest values of present documentation are for the blood and urine analysis registers at 10.9% and 13.0%, respectively.

The highest values are for the fundamental register at 93.6% and the adult visits register with 89.1%. In general, documentation seems to be well kept in a general sense but specific medical areas such as women's obstetric and gynecological health as well as domestic violence cases show relatively lower values for documentation presence.

Table 36

	Percent Yes
Clinical card to follow child	85.1
Temporary disability and maternity	66.5
Death records	65.5
Vaccine cards - children 0-14 years	87.4
Vaccine verification for children	83.9
Unified protocol for family planning	67.0
Field type family planning	63.0
Educational/promo materials	79.6
Elderly homecare register	56.1
Prosecution forms for elderly in homecare	42.4
Fundamental register	93.6
Children visits register	87.7
Adult visits register	89.1
Emergency visits register	86.1
Home visits register	76.2
Filled, refilled, or partially filled prescriptions	69.5
Health books (Libreza e shendetit)	64.4
Visit form and doctor procedures	83.0
Chronic illness register	67.5
Cards for pregnant women	81.8
Fundamental register for pregnant women	74.2
Vaccine register for pregnant women	64.1
Obstetric visit register	58.8
Gynecological register	41.4
Family planning register	59.1

	Percent Yes
Urine analysis register	13.0
Blood analysis register	10.9
Manipulation performance register	66.7
Specialist doctor register	18.6
Driver's license register	22.2
Urine and blood analysis papers	32.1
Cards for children 0-6 years	83.8
Fundamental register for children consultations	76.0
Register for specialty doctor visits for children	62.5
Fundamental vaccine register	85.1
Vaccine application register	83.4
Nurse visit register	68.5
Congenital deformity register	32.7
Arrival and departure register for children 0-14 years	68.1
List of reimbursed medications	70.3
Protocol for reimbursing medications	67.8
Keeps minutes for domestic violence cases	49.6
Report domestic violence cases immediately to the police	68.7
Gets permission from patient to report domestic violence to the police	60.0
Domestic violence register	31.9

As Table 37 presents the regional level data for the key health centers, it can be seen that proper documentation levels are quite high across the regions. The Center leads the way with 90.2% with the North region and South region trailing not far behind. The district crosses tabulations in Table 38 present more detail about high values seen in Table 37. The central districts consistently have high percentages related to "Proper documentation." The lowest percentage for the same classification is in Vlore with 40.0%, then Gjirokaster at 53.3%, and Kukes with 61.5%. Again, this trend is reflected in the equipment and medical inventory cross tabulations. Kukes and Gjirokaster also are the only two districts with key health centers classified with "Improper documentation."

Table 37

	North region	Middle region	South region	Total
Proper documentation	80.7	90.2	71.9	160
Somewhat proper documentation	10.5	8.2	24.4	31
Improper documentation	1.8	0.0	1.2	2
Missing information	7.0	1.6	2.4	7

Table 38

	Proper documentation	Somewhat proper documentation	Improper documentation	Missing Information	Total
North region					
Diber	87.5	12.5	0.0	0.0	16
Kukes	61.5	23.1	7.7	7.7	13
Lezhe	80.0	0.0	0.0	20.0	10
Shkoder	88.9	5.6	0.0	5.5	18
Middle region					
Durres	92.3	7.7	0.0	0.0	13
Elbasan	88.0	8.0	0.0	4.0	25
Tirana	91.3	8.7	0.0	0.0	23
South region					
Berat	72.7	27.3	0.0	0.0	11
Fier	90.9	9.1	0.0	0.0	22
Gjirokaster	53.3	33.3	6.7	6.7	15
Korce	89.4	5.3	0.0	5.3	19
Vlore	40.0	60.0	0.0	0.0	15

5.12 Health Center Closing Time

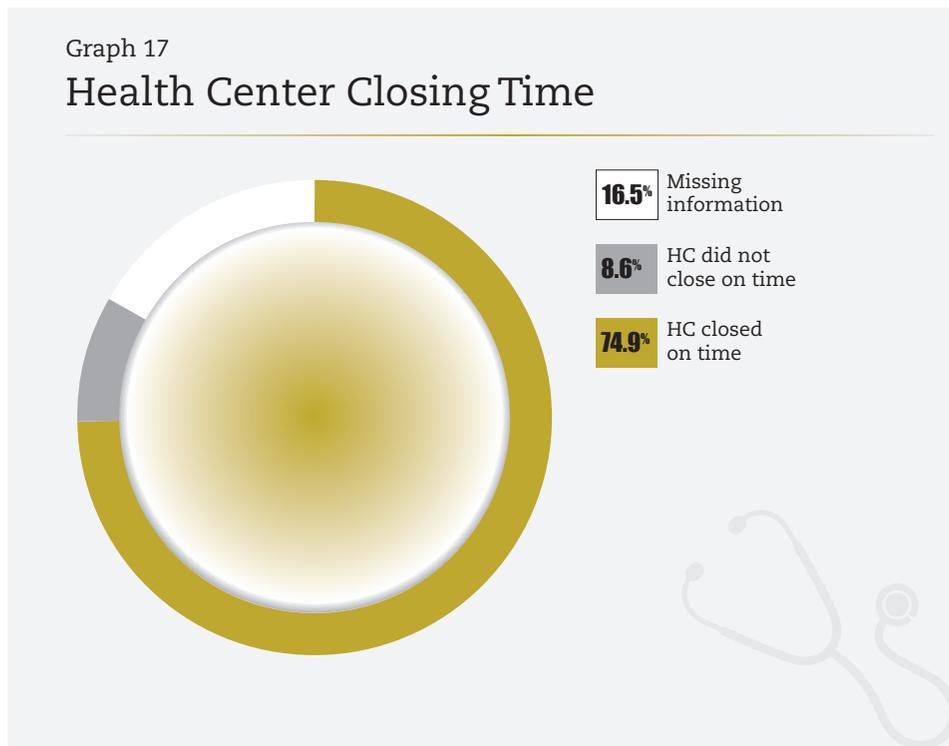
Based on data from the final section of the questionnaire, a scale was created called HC Closing. The answers of the survey questions are

classified as with “on time” or “not on time” based on the selection from the choices listed for each question that are listed below:

1. When is the closing schedule of this health center?
2. When the health center was closed (exact time)?

If the answers to the questions match then it is considered “closed on time” and if the question answers do not match then the health center is considered “not closed on time.”

The tabulations based on the entire sample are shown in Graph 17 and the cross tabulation by health center type are shown in Graph 18.



In general, the health centers closed on time with a frequency of 74.9%. When dividing it into key and satellite health centers the key health centers have a higher value of closing on time compared to the satellite centers with key centers at 88.3% and the satellite at 71.6%. It should be noted that there is more missing data associated with the satellite centers and this could account for the difference in the frequencies.

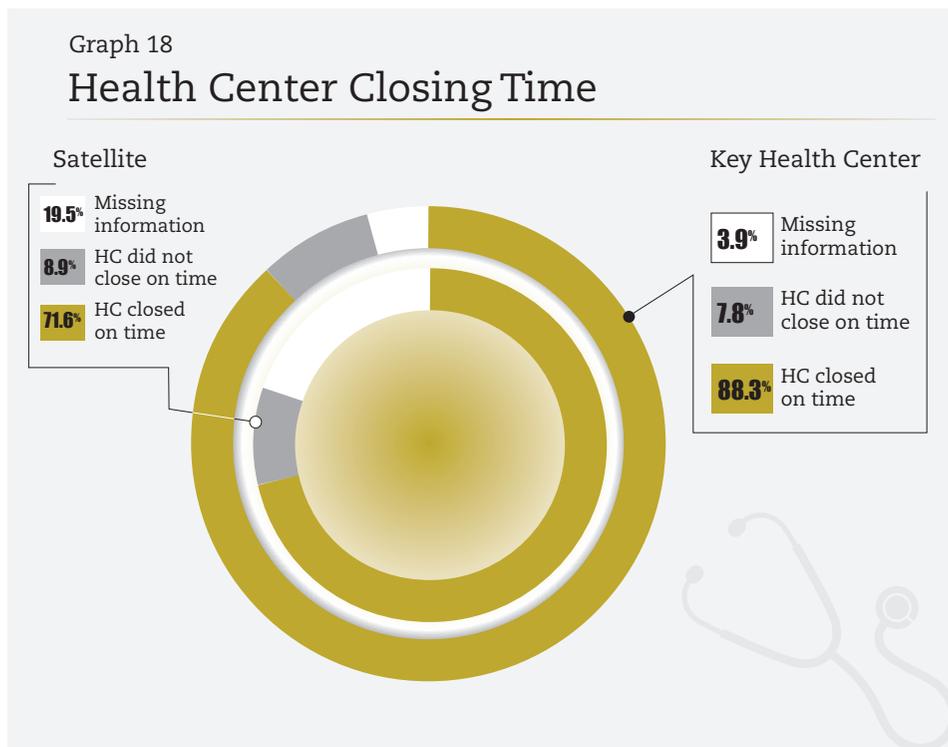


Table 39 below shows the correct answers by question that created the variable HC Closing.

Table 39

	Percent / Correct
When is the closing schedule of this health center?	
<i>Correct answer: On time</i>	62.6
When the health center was closed (exact time)?	
<i>Correct Answer: On Time</i>	61.9

Tables 40 and 41 show the regional and district data for the closing time information. First, for the regional data, the Centre region sampled health centers tend to perform better with closing on time than the North region and South region. The district data shows a similar story with the central districts having consistently high percentages for closing on time. The

lowest value for this category is for Gjirokaster with 37.5%, then Lezhe at 51.4%, and finally Vlore with 68.8%. Kukes was next with 69.2%, continuing to reflect the trend of Gjirokaster and Kukes having low performance values.

Table 40

	North region	Middle region	South region	Total
HC closed on time	73.2	85.5	76.2	428
HC did not close on time	13.1	6.9	6.4	46
Missing information	13.7	7.6	17.5	76

Table 41

	HC closed on time	HC did not close on time	Missing information	Total
North region				
Diber	90.3	3.2	6.5	31
Kukes	69.2	12.8	18.0	39
Lezhe	51.4	29.7	18.9	37
Shkoder	82.6	6.5	10.9	46
Middle region				
Durres	84.4	9.4	6.3	32
Elbasan	83.8	7.5	8.8	80
Tirana	90.9	3.0	6.1	33
South region				
Berat	84.2	10.5	5.3	38
Fier	87.3	6.4	6.4	63
Gjirokaster	37.5	58.3	4.2	48
Korce	80.0	7.3	12.7	55
Vlore	68.8	27.1	4.2	48

Chapter 6

Conclusions and Recommendations

This chapter continues with some key recommendations for improving the performance of primary health care centers in Albania.

What are the strengths and weaknesses of the primary health care centers? What characterizes a health center with strengths or weaknesses?

Based on the findings presented above, it is understood that high values for different variables and their combinations show the strength of a primary health care system institution in Albania. On the other hand low values in percentages show that primary health institutions should improve their performance significantly to serve the Albanian public as required by the approved regulations and packages. Thus the characteristics of a strong health center would be:

- To have an active status and to be operating according to the working hours as displayed;
- To have the appropriate health personnel available for its patients;
- To be properly equipped;
- To open and close on time as per the schedule;
- To have been adapted for people with disabilities and to provide the appropriate services for adults, children and cases of emergency.
- To have active and appropriate relations with the Mandatory Health Care Insurance Fund Healthcare (CHCIF) otherwise known as the Fund and the respective supervising Directorates, according to the mutual contract.
- Demonstrate high quality infrastructure, equipment, medicine and documentation.

Strengths

The strengths of the primary health care in Albania can be observed in the number of active health centers and the procedures for opening and closing them. Observation shows that health care systems are provided properly

throughout the 415 primary health centers by covering health care for adults, pediatric health care and emergency cases. The documentation in the main health care centers was observed to be carefully kept. However, focusing on the separate components of the questionnaire sections, for example on the health care centers' documentation, it is generally well – kept by staff, but on specific aspects, such as seems that he generally well maintained by the staff, but for some specific aspects such as cases of domestic violence or family planning, this documentation is wither inexistent or not well – kept.

The relationship of a health center with the Fund trended at mid to high level, based on the fact that half of the health centers had regular relations with the Fund. The details of these relations show that the agreements, supervision and reporting to the Fund was done regularly and effectively. As another strength, almost two-thirds of the health centers were audited by the Fund.

The gathered data shows that 71.6% of health centers were audited by the Fund and the remaining 28.4% were not.

Weaknesses

A substantial weaknesses of health centers observed was the percentage of centers that were accessible by persons with disabilities, which was about 5% of them. With regard to toilets being accessible, the percentage was even lower, demonstrating that at large health care centers in Albania are not accessible by people with disabilities. Other weaknesses were clearly observed in lack of investments to have the appropriate infrastructure in place in health care centers.

Looking specifically at the questions relating to investments the lowest percentages at this level related to bank loans and donor funds used for investment. Although not as low in percentage, the level of investments by the Ministry of Health was also low, resulting in less than a third of health centers to have received investment from the Ministry of Health. Investments in health centers are allocated in the framework of the Regional Developmental Fund where the local government applies online using an approved form.

This assessment showed that approximately half of health centers were properly equipped with the respective medications. With regard to the question that refers to the usage and replacement of medicaments when supplies run out, according to the PHC managers they are used only in emergency cases due to the limited amounts. Otherwise, patients were prescribed medicine to by from the drugstore. This solution was found

because the health centers could not get new supplies for medicaments prior to the approval of the new budget, thus until the coming year. The same with the issue of medical equipment. In some health centers the equipment were still packed and put in drawers and in some cases they were missing. How soon equipment was replaced after it went out of order also remained unclear. Due to the inventory of the health center, the medical staff could not do away with equipment even when they were out of order. How fast equipment was replaced when they were out of order was also unclear. That required for a long bureaucratic approval procedure and sometimes for undetermined and undefined reasons, the request was rejected.

The components of the health center infrastructure were important elements highlighting that less than one-fifth of health centers meets the two-thirds of the components listed. The main weaknesses are in regard to the lack of a generator to provide electricity, toilets separated by gender and a lack of computers, telephone systems and vehicles including ambulances. Another important component is the high percentage of health centers without a special room for the medical waste/ incinerator.

A final variable that indicates weakness is the fact that approximately one-fifth of the primary health centers are properly equipped with a telephone system, a receptionist, a phone number posted at a visible place at the entrance of the health center. This means that approximately 80 % of the health centers are lacking of these facilities that are key to establishing relations with patients. Due to this insufficiencies, patients are often left to wait, appointments are not made. Thus, in Tirana for example patients prefer to travel to the University Hospital Center "Mother Teresa".

Which investment areas can be considered effective?

Investments are the weak point and are crucial for future improvements the primary health care in Albania. Even in health centers which have demonstrated high levels of infrastructure, equipment, medicine, personnel. there is need for investments to improve the efficiency of the primary health centers. Areas for improvement include infrastructure, equipment and medicine inventories as well as onsite documentations.

To increase the effectiveness of the women care an investment can begin in breast cancer prevention. Health specialists suggest that clinical breast should be done at the health center. In this way the family doctor conduct examinations for women and girls that visit the health center and refer the patients for mammograms if necessary.

The observation clearly showed that the necessary equipment for deliveries was missing in the primary health centers, as well as in ambulances. Regardless of the Ministry of Health Decision that says there can be no deliveries at the health centers due to lack of resuscitation rooms in them, the delivery equipment set should be present for interventions such as emergencies or during the transport of pregnant women from rural areas to the town hospitals. Health centers require for serious investment regard accessibility of centers by disabled people.

Other investments to be made include investments in the telephone, computer and internet systems. Specifically investing in information technology to establish of an electronic database would lead to an improved service and consistent communication between the patients and the medical staff. The investment should not only be technical but also investment in the proper training of medical to use the systems.

Documentation, as mentioned above, was generally well kept, but during the survey it was observed that there are weaknesses in keeping records of domestic violence and it was found that this phenomenon is not reported by the medical or nursing staff.

Infrastructural deficiencies require significant investment. Electricity and water at different temperatures are two elements that are dependent on the local authorities, which are not serving the health centres effectively to date. Generators are required for the appropriate operation of health centers, especially in remote rural areas. Electricity and water are the two elements that when properly secured provide great opportunities to improve and expand the services of a health center. This investment undoubtedly brings about improvements in other components related to infrastructure, such as heating and cooling facilities, storing medications in environments with the appropriate temperature.

Which of the regions: the northern, the middle or the southern regions have urgent needs for investments in the primary health care system?

The data of the survey clearly identified that all Albanian regions need investments because there are no distinct differences between the health care centers in these regions. This is clear in the analysis of data from different variables according to the questionnaire sections and the statistical analysis. Health care centers in the northern region of Albania specifically their equipment, documentation and the closing practices. The organization of health care centers was lacking in almost all districts of the northern region of Albania, whereas within the centre region Elbasan had the lowest percentage, followed by Vlora in the southern region of Albania.

With regard to opening procedures, Vlora holds the highest percentage of about 28 % of centers carrying out irregular opening procedures, followed by Korca and Kukësi in about 20 % of the cases.

Also with regard to the relations established with the Mandatory Health Care Insurance Fund (CHCIF), the health centers in the northern region have irregular relations, but it should be noted that in almost all health centers in Albania, the Fund was not conducting audits on these centers. Whereas with regard to investments, there were very little or none at all in 33% of health care centers across the country. Regarding improper infrastructure, Kukës with 33 % and Elbasan with 25 %. Shkodra 27 % and Gjirokastër 33 % were found to be unequipped to a high level.

Suggestions for future actions

Based on the finding and conclusions above, some suggestions can be made about how to improve the primary health care centers in Albania. These suggested future actions are listed below:

- The Albanian government should allocate 10-12% of the state budget towards health care services.
- The Ministry of Health and the Mandatory Health Care Fund should draft an investment and reform plan with the aim of improving the infrastructure of the 415 primary health care centers.
- Health centers need to manage the respective budget and in cooperation with civil society organizations increase fund – raising capacities.
- Health centers need to strictly follow the available approved packages and register systems and the government should be more diligent in auditing this process.
- Additionally, the Fund should regularly plan and audit all health centers.
- Health services provided at specialized clinics should be unified with the primary care clinics to avoid unnecessary costs.
- Specialized training should be provided for family doctors which could lead to future exploration of the differentiation between general practitioners and family doctors.
- Rural primary health centers must have a nurse and/or midwife on staff at all times.

- Planning and establishing labs at the primary health centers is crucial to enable simple medical tests to be ran on site.
- Improve protocols and policies to increase the independence of the heads of health centers and strengthen the autonomy of the primary health care centers.
- Regional Health Directorates to cooperate with the Ministry of Health and the local government to allocate investments.
- Health centers need to measure patient satisfaction and establish a traceable database with this data in order to improve services.
- Health centers must keep appropriate records according to the needs identified by the periodical reporting of the monitoring and supervising sectors. They should plan training programs on continuous medical education for their medical staff, in cooperation with the health centers.
- Infrastructure with regard to equipment, medication, and documentation must be improved according to approved standards.
- The Ministry of Health and all its institutions should revise their policy documents and strategies from the gender perspective. Albania has stated its commitment for the issues of gender integration into various sectors including health at all levels.
- The Ministry of Health and Health Centers should strengthen partnerships with various stakeholders starting from the ministries, local government institutions and the civil society organizations.

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NATIONAL LEGISLATION

Albanian Charter on the Rights of Patients;

Amended law number 7870 dated October 13, 1994, “On Health Insurance in the Republic of Albania”;

Article 10 of Law No. 10383, dated 24.2.2011, “On the mandatory health care in the Republic of Albania, as amended, upon proposal of the Minister of Health and the Council of Ministers;

Article 4 of Law No. 10107, dated 30.3.2009, “On the health care in the Republic of Albania”, as amended;

Decision of Council Ministers amended number 857, dated December 20, 2006, “On the Contraction of Primary Health Care Services and the General Rules for Contracting Primary Health Care Services”;

Decision of Council Ministers (DCM) No. 857, dated December 20, 2006, “On the Financing of Primary Health Care Services by the Compulsory Health Insurance Scheme;

General Contracting Services for Primary Health Care;

Instruction on Clinical Practice in Primary Health Care;

Law No. 10107, of 30.03.2009 “On the primary health care in the Republic of Albania”;

Law No. 10138 of 11.05.2009 “On public health”;

Law no. 10383, of 24.2.2011 “On mandatory healthcare insurance in the Republic CHAPTER 2 21 of Albania”, as amended;

Law No. 7870, of 13.10 1994 “ On the health insurances in the Republic of Albania”, as amended;

Law No.10107, of March 30, 2009, “On Health Care in the Republic of Albania”;

Law No.10138 of May 5, 2009, “For Public Health”;

List of equipment in the Health Center (minimal standards on physical infrastructure and Standard List of Medical Equipment), according to DCM nr.857, dated 20/12/2006, (amended);

- List of Medical Documentation in the Health Center, approved by the Ministry of Health;
- List of Medication and consumption goods in the Health Center, according to DCM nr.857, dated 20/12/2006, (amended);
- No. 559 Order dated October 26, 2009, for application fees of medical services for patients, according to the “Schedule of Fees for Medical Services for Patients in Primary Health Care and Specialized Hospitals”;
- Quality Standards for the Accreditation of Institutions of Primary Health Care, adopted in February 2009;
- Order No. 49 dated November 2, 2011, for the approval of the regulation “On the Organization and Functioning of Medical Laboratories”;
- Order No. 526 dated December 10, 2009, “On the Implementation of the Referral System in the Health of Patients”;
- Quality Standards for the Accreditation of Institutions of Primary Health Care, adopted in February 2009
- Regulation of the Board of the Health Center Directorate of Public Health and Regional Health Agency Regulation
- Statute of Health Centers
- The Basic Package of Primary Health Care Services, adopted in January 2009
- The Basic Package of Primary Health Care Services, adopted in January 2009
- Quality Standards for the Accreditation of Institutions of Primary Health Care, adopted in February 2009
- The Strategy of Public Health and Health Promotion: “Towards a Healthy Country with Healthy People” –from the Health Reform Project in Albania, USAID, and the Ministry of Health, add the year

Website

http://data.worldbank.org/country/albania#cp_wdi

http://apps.who.int/nha/database/World_Map/Index/en?id=REPORT_4_WORLD_MAPS&mapType=3&ws=0